Health Care Financing

Program Statistics

Medicare and Medicaid Data Book, 1988

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Health Care Financing Administration

Health Care Financing

Program Statistics

The Health Care Financing Administration (HCFA) was established to combine health financing and quality assurance programs within a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of other health care quality assurance programs.

The mission of HCFA is to promote the timely delivery of appropriate and high-quality health care to the 31.7 million Medicare enrollees (in calendar year 1986) and 21.8 million Medicaid recipients (in fiscal year 1985) among the Nation's aged, disabled, and poor. HCFA must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible, and that HCFA policies and actions promote efficiency and quality in the total health care delivery system.

The Office of Research and Demonstrations (ORD) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. In addition, ORD examines the impact of HCFA programs on health care status, utilization, and expenditures, as well as their effect on beneficiary access to services, health care providers, and the health care industry.

The Bureau of Data Management and Strategy (BDMS) operates HCFA's statistical data systems and maintains the national Medicare statistical files. BDMS also serves as the focal point within the agency for information systems policy, planning, and data standards development.

The Office of the Actuary (OACT) directs the actuarial program for HCFA and monitors national health care expenditures and prices. OACT also provides analyses on the costs of current HCFA programs and the impact of possible legislative or administrative changes in the programs.

The *Medicare and Medicaid Data Book, 1988,* is the fifth edition of a report that provides an overview of the Medicare and Medicaid programs. Basic data and analyses of the programs are presented. Trends in enrollees, recipients, use of services, and expenditures are shown, and various aspects of the two programs are described. Also provided are lists of Medicare carriers and intermediaries, Medicaid agencies and fiscal agents, and HCFA offices to call for information.

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Medicare and Medicaid Data Book, 1988

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
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Symbols

—	Data not available
NA	Not applicable
Z	Percentage more than 0 but less than 0.05

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Medicare and Medicaid Data Book, 1988

by Martin Ruther and Thomas Reilly

Executive summary

This volume is the fifth in a series of descriptive statistical reports on the Medicare and Medicaid programs. Medicare data for calendar year 1984 and Medicaid data for fiscal year 1985 are presented. The volume is intended to serve as a resource for public officials, researchers, policy analysts, and consumers who have an interest in these health programs.

In Chapter 1, brief overviews of Medicare and Medicaid are provided, and information is presented on the relationship between these two programs, Federal administration of the programs, and comparative program expenditures. Medicare and Medicaid highlights are:

- Combined Medicare and Medicaid payments may reach $153 billion by fiscal year 1989, according to estimates from the Office of Management and Budget. It is estimated that Medicare benefit payments will account for $98 billion of the total and Medicaid payments will account for $55 billion. The average annual rate of increase of Medicare payments from fiscal year 1983 to fiscal year 1989 is estimated at 10.0 percent, and the rate of increase for Medicaid payments is estimated at 9.1 percent.
- The Office of the Actuary (OACT) preliminary estimates of Medicare benefit payments by type of service indicate that inpatient hospital payments totaled $45.8 billion in calendar year 1986. These payments increased 2.5 percent from calendar year 1985 to calendar year 1986. The small size of the increase, which is less than any other major service, is probably attributable to the Medicare prospective payment system. Physician payments ($18.8 billion) rose 8.6 percent in the same period, and outpatient services ($5.0 billion) rose 17.1 percent.
- OACT estimated that the largest Medicaid payments in fiscal year 1986 were for intermediate care facility services ($11.8 billion), which increased 4.9 percent from fiscal year 1985 to fiscal year 1986, followed by inpatient hospital payments ($11.4 billion), up 7.2 percent, and skilled nursing facility payments ($5.7 billion), up 11.4 percent.
- In calendar year 1984, 20.7 million of the 30.5 million aged and disabled Medicare enrollees received benefits; $59.1 billion were paid on their behalf for health services. In fiscal year 1985, 21.8 million Medicaid recipients had $37.5 billion paid on their behalf.
- In calendar year 1984, the average Medicare payment per reimbursed enrollee was $2,850. The average Medicaid payment per recipient was $1,720 in fiscal year 1985.
- Nearly two-thirds of all Medicare reimbursements in calendar year 1984 were for inpatient hospital care. In contrast, the emphasis in Medicaid is on long-term care, and 43.5 percent of Medicaid payments in fiscal year 1985 were for services in intermediate care facilities and skilled nursing facilities.
- Medicare enrollees were mostly aged persons, 90.5 percent of all enrollees, and the aged received 88.1 percent of all reimbursements in calendar year 1984. The remainder were disabled enrollees, including persons with end stage renal disease.
- The largest proportion of Medicaid recipients were children and adults who became eligible through the Aid to Families with Dependent Children (AFDC) program. Persons covered through AFDC comprised 70.0 percent of all recipients but received only 24.4 percent of all payments in fiscal year 1985.

Trends in the evolution of the Medicare and Medicaid programs are reported in Chapter 2. Trends are described for the number of Medicare enrollees and Medicaid recipients, Medicare and Medicaid expenditures, and the use of and expenditures for hospital inpatient and physicians' services in both programs. Trend data are also presented for other services in each program, including Medicaid long-term care utilization and expenditures. A time series of Medicare deductibles and coinsurance amounts is presented. The chapter ends with a discussion of Medicare and Medicaid expenditures as related to national personal health care expenditures. Highlights of Medicare and Medicaid program trends are:

- From 1966 to 1984, the number of Medicare enrollees (including the disabled after coverage for them began in July 1973) increased at an average annual rate of 2.6 percent. The average age of aged Medicare enrollees also increased. The proportion of enrollees 75 years of age or over grew faster than the proportion 65-74 years of age. This gradual aging has long-term effects because older enrollees are relatively higher users of health care services and raise the average amount reimbursed per enrollee.
- From fiscal year 1973 to fiscal year 1985, the number of Medicaid recipients increased at an average annual rate of growth of 0.9 percent per year. This overall upward trend included periods of both growth and decline.
- Total Medicare benefit payments grew 16.7 percent per year from 1967 to 1984.
- Total Medicaid payments increased at an average annual rate of 13.0 percent from 1973 to 1985.
- From 1967 to 1984, Medicare reimbursements for inpatient hospital services increased from 62.7 percent to 65.1 percent of total reimbursements. The proportion of reimbursements for skilled nursing facility services decreased from 6.5 percent to 0.8 percent in the same period.
- Among aged persons enrolled in Medicare at any time during 1984, persons reimbursed $15,000 or more represented only 2.3 percent of enrollees but accounted for 31.8 percent of Medicare reimbursements for the aged.

- Among disabled persons enrolled in Medicare at any time during 1984, 3.9 percent were reimbursed $15,000 or more, and this group accounted for 48.3 percent of all Medicare reimbursements for the disabled. At the other extreme, 41.7 percent of disabled enrollees received no reimbursement.
- In fiscal year 1985, aged, blind, and disabled persons comprised 27.9 percent of all Medicaid recipients but accounted for 73.5 percent of all Medicaid payments. Children in the Aid to Families with Dependent Children category accounted for 44.7 percent of all Medicaid recipients but only 11.8 percent of all Medicaid payments.
- According to the Medicare archival reimbursement abstract, in 1974, the first full year of Medicare coverage for patients with end stage renal disease (ESRD), reimbursements for ESRD enrollees were $240 million. By 1984, reimbursements for ESRD patients were $2,090 million, an average annual increase of 24 percent.
- Reimbursements per ESRD enrollee rose from $15,000 in 1974 to $22,200 in 1984, an annual growth rate of only 4.0 percent. The low rate is largely because of limits placed on charges for kidney dialysis treatments and the increasing success of transplantation. Patients with a functioning kidney graft incur considerably lower medical expenses than those on dialysis.
- In 1978, only 11 percent of the Medicare ESRD population had a functioning kidney graft. By 1985, the comparable figure was 19 percent.
- Medicare enrollees paid $3.4 billion in hospital insurance (HI) cost sharing (deductible and coinsurance) and $6.1 billion in supplementary medical insurance (SMI) cost sharing in calendar year 1984.
- From 1977 to 1984, HI cost sharing for aged and disabled enrollees rose at an average annual rate of nearly 18 percent, and the SMI cost-sharing rise averaged nearly 14 percent. However, from 1983 to 1984, the coinsurance amount of the aged and disabled decreased 15 percent. The introduction of the prospective payment system may have been a factor in the decrease in the average length of hospital stays, which, in turn, lowered the number of coinsurance days and the amount of coinsurance liability.
- Medicare payments rose from 10.9 percent of all national personal health care expenditures in 1970 to 19.0 percent in 1985.
- In the same period, Medicaid payments increased at a slower rate, from 8.0 percent of national personal health care expenditures to 10.7 percent.

In Chapter 3, the major characteristics of the Medicare program are described, accompanied by program statistics. Medicare eligibility, benefits, financing, and administration are outlined for both the hospital insurance and supplementary medical insurance programs. Data are presented on enrollment and expenditures for the aged and disabled. Detailed information is provided on Medicare financing and administration, the use of Medicare benefits, and the distribution of reimbursements for various services by different categories of enrollees. The chapter concludes with a description of Medicare's arrangements with group health plans and a discussion of the Medicare statistical system, including a description of data on reimbursement for physicians and other suppliers of services. Highlights from Chapter 3 are:

Persons served and reimbursement per person, 1984

- Much larger proportions of aged and disabled enrollees received supplementary medical insurance benefits than hospital insurance benefits. However, for both groups, average payments per person served were far higher for HI than for SMI.
- The proportion of aged enrollees receiving various types of Medicare benefits was successively higher with increasing age. By far the largest proportion of aged enrollees received physicians' services, followed by outpatient and then inpatient hospital services.
- Among the aged, larger proportions of white enrollees than all other enrollees received Medicare benefits for inpatient hospital, skilled nursing, and physicians' services. Larger proportions of aged enrollees of all other races received outpatient and home health services.
- Aged persons of all other races had higher reimbursements per person served than white persons for all services.

A larger proportion of aged females than aged males received benefits for all services except inpatient hospital services.

- Reimbursement per aged person served was highest for inpatient hospital services ($5,502), followed by skilled nursing facility services ($1,580) and home health agency services ($1,096). Comparable figures for SMI services were $729 for physicians' services and $319 for outpatient services.

Hospital insurance benefits, 1984

- For aged enrollees, short-stay hospital discharges per 1,000 enrollees and covered days of care per 1,000 enrollees increased with age.
- The hospital discharge rate for aged white enrollees exceeded that for all other aged enrollees. However, aged persons of all other races had longer average lengths of stay and higher charges per discharge than white persons.
- The proportion of aged enrollees who received skilled nursing facility (SNF) benefits was more than three times higher than that of the disabled.
- Among both the aged and the disabled, higher proportions of females than males received SNF benefits.

Prospective payment system

- In the first two full calendar years of the prospective payment system, the total number of discharges from short-stay hospitals decreased substantially. Discharges fell 9.1 percent from 1984 to 1985. In the same period, the average length of stay for all

discharges fell from 8.9 to 8.6 days. However, the average length of stay for hospitals under the prospective payment system was unchanged, 7.8 days, in 1984 and 1985. Reimbursements increased from $38.5 billion in 1984 to $40.2 billion in 1985, or $1.7 billion, the smallest such increase in the 1980's.

Supplementary medical insurance benefits, 1984

- The proportion of persons using physicians' services was similar for aged and disabled enrollees. However, average reimbursements per person served were nearly one-quarter higher for disabled than for aged persons.
- For aged and disabled enrollees combined, Medicare carriers reduced total physicians' charges by 26.3 percent.
- Among the aged, Medicare reimbursed 67.3 percent of physicians' charges due (total charges less the reduction amount on assigned claims). The remainder, 32.7 percent, was the liability of the Medicare patient. It consisted of coinsurance, 14.7 percent; the reduction on unassigned claims, 11.3 percent; and the deductible, 6.7 percent.
- For outpatient services, both the proportion of persons reimbursed and the average reimbursement were higher for disabled than for aged enrollees. This reflected, in part, the use of dialysis services by disabled enrollees with ESRD.

Group health plans

- Prospective capitation payments provided a new incentive for group health plans to cover Medicare enrollees on an at-risk basis. As evidence of this incentive, the combined Medicare enrollment in risk plans rose 27 percent, from 781,000 in November 1986 to 990,000 in November 1987.

Detailed data on the Medicaid program are reported in Chapter 4. Descriptions of Federal rules and State options are followed by information on State provisions for eligibility and benefits. Statistical data are presented on service use and expenditures for each Medicaid jurisdiction. During the development of this publication, when Federal and State Medicaid data were found to differ, State data were used. Hence, the data in this publication may differ slightly from those in other Health Care Financing Administration publications.

Contained in Chapter 4 are descriptions of Medicaid financing and administration, including matching rates for Federal financial participation, recipients and expenditures under State "buy-in" programs with Medicare, number of certified providers, adoption of Medicaid Management Information Systems, Federal Medicaid assistance percentages, and the Medicaid data system.

Highlights from Chapter 4 follow.

Number of Medicaid recipients and payments, fiscal year 1985

- Of the 21.8 million total Medicaid recipients, 73.2 percent received cash assistance. Cash recipients accounted for 51.5 percent of all vendor payments.
- Although 70.0 percent of all recipients were in the AFDC-related group, they accounted for only 24.4 percent of all vendor payments.
- The blind and disabled accounted for 35.9 percent of total payments but only 13.8 percent of total recipients.
- Females comprised 64.1 percent of all recipients and also accounted for the larger share of total vendor payments (65.4 percent).
- Recipients 65 years of age or over accounted for the largest share of total vendor payments (40.8 percent) but represented only 17.1 percent of all recipients.

Service coverage and limitations

- In fiscal year 1985, 30.0 percent of all vendor payments were for intermediate care facilities (ICF's), followed by inpatient hospital services (including general and mental hospitals), 28.4 percent, and skilled nursing facilities, 13.5 percent.
- As of October 1986, the most frequently offered optional services, based on the number of States and territories offering them, were prescribed drugs (51), and optometrists', clinic, and ICF services (50 each).
- In March 1986, 46 States (including the District of Columbia) limited inpatient hospital services, 42 States limited outpatient hospital services, and 45 limited physicians' services. Thirty-six States limited services covered in skilled nursing facilities.

Federal Medicaid assistance percentage

- The Federal share of State medical vendor payments is based on State per capita income. During fiscal years 1984 and 1985, 17 States received the minimum Federal Medicaid assistance percentage of 50 percent; Mississippi, the State with the lowest per capita income, received the highest, 77.6 percent.

This volume contains several appendixes to help the reader understand and identify additional sources of information. Names and addresses are listed for Medicare intermediaries and carriers. Telephone numbers are supplied for Medicaid State agencies and medical assistance programs and for the Health Care Financing Administration offices responsible for various facets of the Medicare and Medicaid programs. A glossary and list of acronyms used in this report are also included.

1. Introduction to Medicare and Medicaid

In this chapter, the major characteristics of the Medicare and Medicaid programs are outlined. Information is also presented on the relationship between the two programs, including a description of coverage for persons eligible under both programs. In addition, material is provided on how much each program spends (in total and per enrollee or per recipient) in each State and how the Federal Government is organized to administer both programs.

Overview of Medicare program

The Medicare program covers hospital, physicians', and other medical services for most persons 65 years of age or over, disabled persons entitled to social security cash benefits for at least 24 months, and most persons with end stage renal disease. Total Medicare benefit payments (reimbursements and other payments from Medicare trust funds) totaled $74.0 billion in calendar year 1986.

Medicare has two complementary but distinct parts: hospital insurance (HI) also called Part A, and supplementary medical insurance (SMI), also called Part B. The HI program covers 90 days of inpatient hospital care in a benefit period (spell of illness), which begins with the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 consecutive days. There is no limit to the number of benefit periods an individual may use. The program also provides a nonrenewable (lifetime) reserve of 60 days if a beneficiary exhausts the 90 days available in a benefit period.

In addition to inpatient hospital care, the HI program covers up to 100 posthospital days in an SNF if the beneficiary is certified to require such care. The HI program also covers home health agency visits.

About 95 percent of the Nation's aged are enrolled in the HI program. On July 1, 1966, when Medicare became operational, 19.1 million aged persons were enrolled. By July 1, 1984, the number of enrollees had increased to 30.5 million; this total included 2.9 million disabled enrollees. (Medicare coverage of the disabled began on July 1, 1973.)

Nearly everyone covered by HI voluntarily enrolls in SMI. Unlike HI, SMI requires a monthly premium payment, $17.90 per month as of January 1987. Under buy-in agreements, most State Medicaid programs pay these premiums for persons who qualify for both Medicaid and Medicare benefits. The SMI program provides payments for physicians as well as related services and supplies ordered by physicians. SMI also covers outpatient hospital services, rural health clinic visits, and home health visits.

Several health care services that the aged generally use, such as routine eye examinations and preventive services, are not covered by Medicare. Drugs and certain dental procedures are covered only if provided during an authorized hospital inpatient stay. Also, neither intermediate nursing care nor long-term nursing care is provided.

Both the HI and SMI programs require beneficiary cost sharing. Under HI, the patient is required to pay an inpatient hospital deductible for each benefit period. The Secretary of Health and Human Services set the annual HI deductible each year through 1986 based on a formula specified by law. However, Congress set the 1987 deductible at $520 and revised the formula for calculating the deductible in future years. The coinsurance amount continues to be based on percentages of the inpatient hospital deductible. Coinsurance equal to one-fourth of the hospital deductible is required for the 61st through 90th day of inpatient hospital care; an amount equal to one-eighth of the deductible is required for the 21st through 100th day of SNF care; and an amount equal to one-half of the deductible is required for the 60 lifetime reserve days for inpatient hospital care. The patient is also liable for the cost or replacement of the first three pints of blood in a benefit period.

Under SMI, in addition to paying a monthly premium, the beneficiary must pay a $75 deductible each year. (The Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, raised the deductible from $60 to $75, effective January 1, 1982.) Physicians can accept or reject assignment. Acceptance of assignment means participating physicians agree to accept as full payment the amount Medicare allows for the service. The program reimburses 80 percent of allowed (reasonable) charges directly to the physician. Beneficiaries are liable for the remaining 20 percent of allowed charges (coinsurance). Nonparticipating physicians do not agree to accept assignment. On unassigned claims, the beneficiary is responsible for the difference between the physician's charge and the allowed charge as well as the 20-percent coinsurance. (Benefits under SMI and the participating and nonparticipating physician program are discussed in more detail in Chapter 3.) The Medicaid program assumes cost sharing for Medicaid beneficiaries covered under buy-in agreements. (As of calendar year 1985, 49 States and jurisdictions had a buy-in program.) The buy-in program is discussed in more detail later in this chapter.

Medicare benefits and administrative expenses are paid from two separate trust funds. The HI trust fund is financed primarily through a tax on current earnings from employment covered under the Social Security Act. The SMI trust fund is financed through premiums paid by or on behalf of persons enrolled in the program and from general revenues of the Federal Government.

Overview of Medicaid program

Medicaid is a federally supported and State-administered assistance program providing medical care for certain low-income individuals and families. Medicaid accounted for $37.5 billion in Federal and

State expenditures for medical services in fiscal year 1985.

The program is designed to provide medical assistance to people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act: title IV–A, the program of Aid to Families with Dependent Children, or title XVI, the Supplemental Security Income program for the aged, blind, and disabled. In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid. (Chapter 4 contains a more detailed discussion of the major differences among jurisdictions in the criteria used to determine program eligibility.) In addition, States may provide Medicaid to the medically needy, that is, people who:

- Fit into one of the categories of people covered by the cash assistance programs. Most commonly, these are aged, blind, or disabled individuals or members of families with dependent children when one parent is dead, absent, incapacitated, or, at State discretion, unemployed.
- Are not recipients of cash assistance but have income, after deducting medical expenses, that falls below certain levels.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and X–ray services, SNF services for individuals 21 years of age or over, home health services for individuals eligible for SNF services, physicians' services, family planning services, rural health clinic services, nurse–midwife services, and early and periodic screening, diagnosis, and treatment services for individuals under 21 years of age. In addition, States may elect to provide a number of other services, including drugs, eyeglasses, private–duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21 years of age, physical therapy, and dental care.

Medicaid is a vendor payment program; payments are made directly to providers of service for care rendered to eligible individuals. Providers who choose to participate in the program must accept the Medicaid reimbursement levels as full payment. In some cases, recipients share in paying for their care. Individuals in long–term care institutions must turn over income in excess of their personal needs and the maintenance needs of their spouses to help pay for their care. With the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248), States were given permission to require the categorically eligible to share costs for optional services,[1] and they may require medically needy recipients to share in the cost of all services. In general, copayment amounts must be nominal. Certain services are exempt from copayments altogether, for example, pregnancy and emergency services. As noted earlier, most State Medicaid programs have buy–in agreements with Medicare. Under these agreements, Medicaid pays the Part B Medicare premiums and cost sharing for persons covered under both programs.

Medicaid is financed jointly with State and Federal funds. Federal contributions vary with States' per capita income and currently range from 50 percent to 78 percent of program medical expenditures. Administration, fraud and abuse program, and Medicaid Management Information System costs are matched at other rates.

States participate in the Medicaid program at their option. All States except Arizona currently have a Medicaid program.[2] The District of Columbia, Puerto Rico, Guam, American Samoa, the Northern Marianas, and the Virgin Islands also provide Medicaid coverage. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms. Some States also include persons not eligible for Federal matching (State–only or medically indigent persons) in their medical assistance programs but receive no Federal contributions for the costs of their care. As a result, the characteristics of Medicaid programs vary considerably from State to State.

Comparison of Medicare and Medicaid

Data: Sources and characteristics

The marked differences in the statistical systems supporting the Medicare and Medicaid programs obviously limit comparisons of the two programs. In this section, some differences between the data of the two statistical systems presented in this report are discussed.

The Medicare statistical system collects data on enrollees, that is, persons eligible for Medicare. In addition, data are shown for enrollees who received services for which reimbursements were made (referred to as persons served). In contrast, Federal Medicaid statistics consist of aggregate counts of the number of recipients (as opposed to enrollees) and dollars expended on covered services.

Most of the Medicare statistics in this report are produced from the Medicare statistical system, which contains the universe of claims that are processed in the Central Office of the Health Care Financing Administration (HCFA) in Baltimore. The Central Office also tabulates data on the services used by each person reimbursed. Medicaid statistics also are maintained in the Central Office, but only after they have been aggregated in recipient and expenditure counts by the States. These data are reported annually to HCFA by the

[1] The act also made a number of other changes in the Medicaid program, such as allowing for coverage of home care for certain disabled children and the establishment of a Medicaid program in American Samoa.

[2] The Arizona Health Care Cost Containment System became effective on November 9, 1981. This program provides acute health care services to the poor on a prepaid capitated basis. This system currently is being conducted as a demonstration program supported by the Health Care Financing Administration.

Medicaid jurisdictions. Unlike most Medicare data, HCFA data on the Medicaid program cannot be disaggregated by individual person. Thus, the range of analyses is more limited for Medicaid statistics than for Medicare statistics.

Medicare claims data are generally reported for the calendar year in which medical services were rendered rather than the date when Medicare payment was made. Conversely, Medicaid recipient and expenditure counts included in the following tables were reported for the fiscal year in which services were paid. More information on the Medicare and Medicaid data systems is contained in Chapters 3 and 4, respectively.

State buy-in coverage

Through State buy-in agreements, about 11 percent of aged and disabled SMI Medicare enrollees were also covered by State Medicaid programs in calendar year 1985. States can obtain SMI coverage for these eligibles under buy-in agreements with Medicare. States that buy in pay the SMI premium and are responsible for Medicare cost sharing. When persons are eligible under both programs, Medicare is the primary payer for Medicare services, and Medicaid pays the deductible and coinsurance. States receive Federal matching payments for these expenditures. Although States may buy into Medicare for any of their Medicare-Medicaid eligibles, they receive Federal matching funds on premium payments only for persons receiving cash assistance (the categorically needy). States must pay the full cost of premium payments for other Medicaid eligibles.

If a State does not buy SMI coverage for Medicare-Medicaid eligibles, it cannot receive Federal matching payments for services that would have been covered under SMI. Almost all States and jurisdictions with Medicaid programs had buy-in arrangements as of calendar year 1985. (Alaska, Louisiana, Oregon, Wyoming, and Puerto Rico did not have buy-in arrangements.)

State Medicaid programs provide many services for the aged and disabled that are not provided by Medicare, including SNF care beyond the 100-day posthospital benefit provided by Medicare, long-term care in intermediate care facilities (ICF's), prescription drugs, eyeglasses, and hearing aids. In terms of the range of benefits that a State may provide, Medicaid is more comprehensive than Medicare. However, States have broad flexibility to define limits on the amount, duration, and scope of the services they cover; in this respect, Medicaid coverage in a particular State may be more limited than Medicare coverage.

Medicaid also has a more pronounced long-term care orientation. Federal Medicaid legislation does not limit the length of stay of a recipient in a nursing home. Additionally, by law, States are allowed to cover ICF services, but Medicare does not. In 1985, 43.5 percent of Medicaid program expenditures were for long-term care services.

Medicare and Medicaid expenditures

In Table 1.1 are shown total program payments—Medicare benefit payments and Medicaid assistance payments—for fiscal years 1983-89. The 1987-89 data are estimates from HCFA's Office of Management and Budget assuming that current law continues over this time period. The Office of Management and Budget estimated that payments for Medicare and Medicaid combined will increase from $88 billion in fiscal year 1983 to $153 billion in fiscal year 1989. In fiscal year 1989, Medicare benefit payments may total $98 billion and Medicaid assistance payments may reach $55 billion. The average annual rate of change, according to the Office of Management and Budget, may be an increase of 10.0 percent for Medicare payments and 9.1 percent for Medicaid payments.

Table 1.1

Medicare benefit payments and Medicaid payments: Fiscal years 1983-89

Fiscal year	Total	Medicare benefit payments	Medicaid payments[1]
		Amount in billions	
1983	$88.0	$55.6	$32.4
1984	94.8	60.9	33.9
1985	107.1	69.6	37.5
1986	115.1	74.2	40.9
1987	125.2	77.7	47.5
1988	138.0	87.1	50.9
1989	153.1	98.4	54.7
		Percent	
ACRG[2]	9.7	10.0	9.1

[1] Includes Federal and State shares.
[2] Annual compound rate of growth.

SOURCES: 1983-86 data: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates. 1987-89 data: Office of Management and Budget estimates assuming current law.

In Table 1.2 are Office of the Actuary (OACT) preliminary estimates of Medicare and Medicaid payments by type of service. OACT estimated that Medicare trust fund benefit payments increased 5.0 percent from calendar year 1985 to calendar year 1986. The largest payments were for inpatient hospital services, which increased only 2.5 percent. This relatively low rate of increase was probably the result of the Medicare prospective payment system. Next in size were payments for physicians' services, which rose 8.6 percent, followed by payments for outpatient services, which increased 17.1 percent. OACT estimated that Medicaid payments rose 9.0 percent from fiscal year 1985 to fiscal year 1986. The largest payments were for ICF services, which increased 4.9 percent. Next in size were payments for inpatient hospital services, up 7.2 percent, followed by skilled nursing facility payments, up 11.4 percent.

Table 1.2

Medicare benefit payments in calendar years 1985–86 and Medicaid payments in fiscal years 1985–86, by type of service

Type of service	Medicare benefit payments			Medicaid payments		
	Amount in millions		Percent change	Amount in millions		Percent change
	1985	1986	1985–86	1985	1986	1985–86
Total	$70,527	$74,036	5.0	$37,508	$40,878	9.0
Inpatient hospital	44,653	45,754	2.5	10,645	11,407	7.2
Physicians'	17,312	18,800	8.6	2,346	2,545	8.5
Outpatient	4,311	5,049	17.1	1,789	1,983	10.8
Skilled nursing facility[1]	623	607	−2.6	5,073	5,651	11.4
Intermediate care facility (ICF)	NA	NA	NA	11,245	11,798	4.9
ICF/MR[2]	NA	NA	NA	4,719	5,033	6.7
ICF, all other	NA	NA	NA	6,526	6,765	3.7
Home health agency	2,349	2,503	6.6	1,120	1,352	20.7
Group health plan	720	705	−2.1	—	—	—
Prescribed drugs	NA	NA	NA	2,315	2,692	16.3
Other[3]	559	618	10.6	2,975	3,450	16.0

[1] Hospices included in Medicare skilled nursing facility counts.
[2] Intermediate care facility for the mentally retarded.
[3] For Medicare: Independent laboratory. For Medicaid: Dental; other practitioners'; laboratory and radiological; family planning; clinic; early and periodic screening, diagnosis and treatment; and other care services.

NOTE: Data are preliminary.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Table 1.3

Medicare enrollees, persons served, and reimbursements in calendar year 1984 and Medicaid recipients and payments in fiscal year 1985, by area

Area[1]	Medicare		Medicaid recipients in thousands	Medicare reimbursements in millions[3]	Medicaid payments in millions	Medicare reimbursement per person served[3]	Medicaid payment per recipient
	Enrollees in thousands[2]	Persons served in thousands					
All areas	30,455.4	20,749.2	21,808.3	$59,132.2	$37,507.6	$2,850	$1,720
United States	29,824.4	20,604.9	20,219.9	58,915.5	37,364.4	2,859	1,848
Alabama	522.9	350.3	316.2	884.2	375.4	2,524	1,187
Alaska	16.6	10.4	24.0	35.3	66.5	3,393	2,768
Arizona[4]	388.9	267.9	NA	707.9	NA	2,642	NA
Arkansas	362.1	241.1	197.3	564.8	358.3	2,342	1,816
California	2,851.0	2,067.1	3,380.7	6,989.0	4,045.3	3,381	1,197
Colorado	295.3	197.6	147.3	508.0	315.8	2,571	2,144
Connecticut	426.9	313.4	217.4	853.8	594.9	2,724	2,736
Delaware	74.2	54.1	40.6	133.7	70.5	2,471	1,738
District of Columbia	78.0	56.3	98.3	212.2	297.7	3,768	3,029
Florida	1,934.8	1,415.6	561.9	4,025.7	943.1	2,844	1,678
Georgia	637.6	437.5	468.9	1,079.8	759.6	2,468	1,620
Hawaii	97.5	65.3	92.2	163.6	140.4	2,505	1,522
Idaho	114.6	77.3	38.8	178.5	76.3	2,309	1.965
Illinois	1,420.3	919.8	1,063.4	3,179.4	1,652.9	3,457	1,554
Indiana	685.2	442.3	284.0	1,231.3	746.7	2,784	2,630
Iowa	431.9	289.8	211.9	677.9	359.9	2,339	1,698
Kansas	338.4	243.8	141.7	643.9	256.3	2,641	1,809
Kentucky	487.0	301.6	408.2	702.2	539.8	2,328	1,322
Louisiana	463.1	272.5	416.2	833.2	725.3	3,058	1,743
Maine	166.6	121.9	124.4	281.1	232.4	2,306	1,868
Maryland	466.6	337.1	328.8	1,084.4	583.9	3,217	1,776
Massachusetts	814.0	529.7	522.9	1,617.9	1,432.6	3,054	2,739
Michigan	1,109.3	854.3	1,133.3	2,620.1	1,516.6	3,067	1,338
Minnesota	542.0	344.1	357.3	822.1	1,001.1	2,389	2,802
Mississippi	339.1	221.7	299.7	558.9	274.4	2,521	916

See footnotes at end of table.

Table 1.3—Continued

Medicare enrollees, persons served, and reimbursements in calendar year 1984 and Medicaid recipients and payments in fiscal year 1985, by area

Area[1]	Medicare		Medicaid	Medicare	Medicaid	Medicare	Medicaid
	Enrollees in thousands[2]	Persons served in thousands	recipients in thousands	reimbursements in millions[3]	payments in millions	reimbursement per person served[3]	payment per recipient
Missouri	729.6	480.7	356.0	$1,516.9	$524.9	$3,156	$1,474
Montana	103.3	67.0	47.3	157.6	95.5	2,352	2,019
Nebraska	225.6	139.7	93.9	343.4	167.1	2,458	1,779
Nevada	93.3	60.8	28.2	212.2	65.7	3,490	2,328
New Hampshire	121.9	83.4	37.7	183.4	118.0	2,199	3,129
New Jersey	1,003.0	723.5	581.4	2,209.9	1,144.7	3,054	1,969
New Mexico	145.2	93.6	87.3	243.3	148.3	2,600	1,698
New York	2,402.3	1,792.6	2,242.1	5,089.1	7,588.0	2,839	3,384
North Carolina	752.2	493.1	343.2	1,135.8	646.7	2,303	1,884
North Dakota	91.9	65.5	36.7	162.8	116.7	2,485	3,183
Ohio	1,385.1	944.7	1,045.1	2,562.1	1,767.4	2,712	1,691
Oklahoma	414.9	260.6	270.0	694.7	460.4	2,666	1,706
Oregon	364.5	244.8	152.5	610.6	238.7	2,494	1,565
Pennsylvania	1,787.9	1,303.9	1,071.0	4,042.6	1,797.4	3,100	1,678
Rhode Island	147.0	116.3	100.8	295.3	250.0	2,539	2,482
South Carolina	368.2	230.7	237.6	547.9	309.4	2,375	1,302
South Dakota	102.4	66.0	33.8	152.6	94.4	2,313	2,790
Tennessee	616.7	393.7	362.1	1,085.1	577.8	2,756	1,596
Texas	1,561.9	1,022.8	761.3	3,115.7	1,413.9	3,046	1,857
Utah	132.3	87.3	72.2	198.4	109.7	2,272	1,519
Vermont	68.3	48.0	50.4	91.0	89.4	1,896	1,775
Virginia	617.1	423.4	303.0	1,083.8	546.9	2,560	1,805
Washington	519.3	364.4	326.4	875.3	584.1	2,402	1,789
West Virginia	286.6	182.1	211.4	455.5	173.2	2,501	819
Wisconsin	654.4	454.8	473.3	1,189.1	942.2	2,615	1,991
Wyoming	44.2	28.0	19.5	69.2	28.2	2,472	1,444
State unknown	21.9	1.0	NA	3.6	NA	3,582	NA
U.S. territories and possessions[5]	393.7	137.5	1,588.5	198.3	143.2	1,442	90
Guam	2.9	1.0	—	3.3	—	3,266	—
Puerto Rico	383.9	134.4	1,571.9	189.1	139.1	1,407	89
Virgin Islands	5.8	2.1	16.6	5.9	4.1	2,809	249
Foreign countries	237.3	6.8	NA	18.4	NA	2,711	NA

[1] For Medicare, area of enrollee. For Medicaid, area of provider of medical services.
[2] As of July 1, 1984.
[3] Hospital insurance reimbursement amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA–1450 plus prospective payment system short–stay hospital inpatient passthrough expenditures reported on the HCFA intermediary benefit payment report.
[4] Arizona does not have a Medicaid program.
[5] Includes all other outlying areas.

NOTES: Medicare data are for services rendered during calendar year 1984; Medicaid data are for services paid for during fiscal year 1985.

SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Medicare and Medicaid population and expenditures

In Table 1.3, Medicare and Medicaid population data and expenditures are compared. In calendar year 1984, 20.7 million (68.1 percent) of the 30.5 million aged and disabled persons enrolled in Medicare received Medicare reimbursements. In fiscal year 1985, 21.8 million persons received health services paid for by Medicaid. About one-quarter of all persons served under the Medicare program resided in California, New York, or Florida. For Medicaid, the three States with the largest number of recipients in fiscal year 1985 were California, New York, and Michigan, which together accounted for 31 percent of all Medicaid recipients.

In calendar year 1984, Medicare reimbursements totaled $59.1 billion; in fiscal year 1985, $37.5 billion were spent on behalf of Medicaid recipients. Medicare reimbursements in calendar year 1984 were largest for California residents (1.5 billion) and Pennsylvania

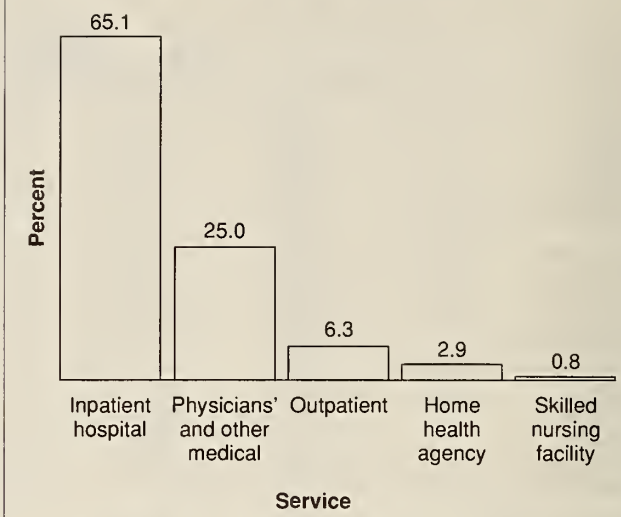
and Florida ($4.0 billion each) were next in size. Together, these four States accounted for 34 percent of total Medicare reimbursements. Payments for Medicaid recipients in fiscal year 1985 were largest in New York ($7.6 billion), California ($4.0 billion), Pennsylvania ($1.8 billion), Ohio ($1.8 billion), and Illinois ($1.7 billion). These five States accounted for 45 percent of total Medicaid expenditures.

The average Medicare reimbursement per person served was $2,850 in calendar year 1984. The average payment per Medicaid recipient was $1,720 in fiscal year 1985. Medicare enrollees in the District of Columbia had the largest reimbursement per person served ($3,768), with total reimbursements of $212 million. Next in size were Nevada ($3,490), with total reimbursements of $212 million, and Illinois ($3,457), with total reimbursements of $3,179 million. Payments per Medicaid recipient in fiscal year 1985 were highest in New York ($3,384), with total payments of $7,588 million; North Dakota ($3,183), with total payments of $117 million; and New Hampshire ($3,129), with total payments of $118 million.

Several important differences between Medicare and Medicaid are illustrated in Figures 1.1 through 1.3. As shown in Figure 1.1, Medicare is oriented toward acute care services, consistent with its statute. Inpatient hospital care accounts for nearly two-thirds of total Medicare reimbursements (HI and SMI combined). Less than 1 percent of Medicare reimbursements go to SNF's, with coverage limited to short-term posthospital recuperative or rehabilitative care. In contrast, as shown in Figure 1.2, inpatient hospital services absorb only 28.4 percent of total Medicaid payments, with payments for long-term care in nursing homes, both ICF's and SNF's, making up 43.5 percent of the total Medicaid payments.

Medicare and Medicaid also differ in the relative size and distribution of reimbursements among their enrollee and eligibility groups. As shown in Figure 1.3, Medicare services predominantely the aged, who comprise 90.5 percent of all enrollees and receive 88.1 percent of all reimbursements. Medicaid aged, blind, and disabled make up 27.9 percent of all recipients but are responsible for 73.5 percent of all payments. In contrast, children and adults eligible through the Aid to Families with Dependent Children category make up 70.0 percent of all Medicaid recipients but account for only 24.4 percent of total payments.

Figure 1.1
Percent distribution of Medicare reimbursements, by type of service: Calendar year 1984



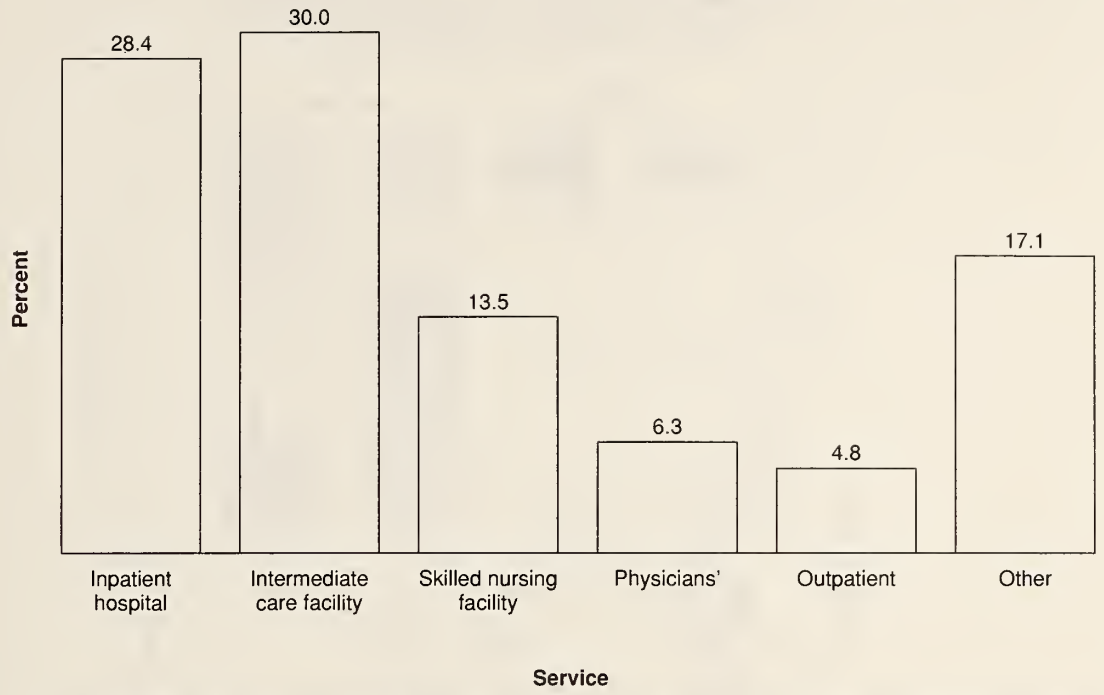
SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Program administration

Medicare and Medicaid were administered by separate agencies in the Department of Health, Education, and Welfare from 1965 to 1977. In 1977, these agencies were merged into the Health Care Financing Administration within the Department of Health and Human Services. Under the new structure, the operation of Medicare and Medicaid is combined, with each newly created bureau or office dealing with a specific aspect of both programs. These changes were designed to reduce duplication of effort and enhance consistency and coordination of Medicare and Medicaid. An intermediate level of associate administrators was added in 1981. Starting in 1987, the four associate administrators and the four staff offices shown in Figure 1.4 report to the Administrator, Deputy Administrator, and Executive Associate Administrator.

Figure 1.2

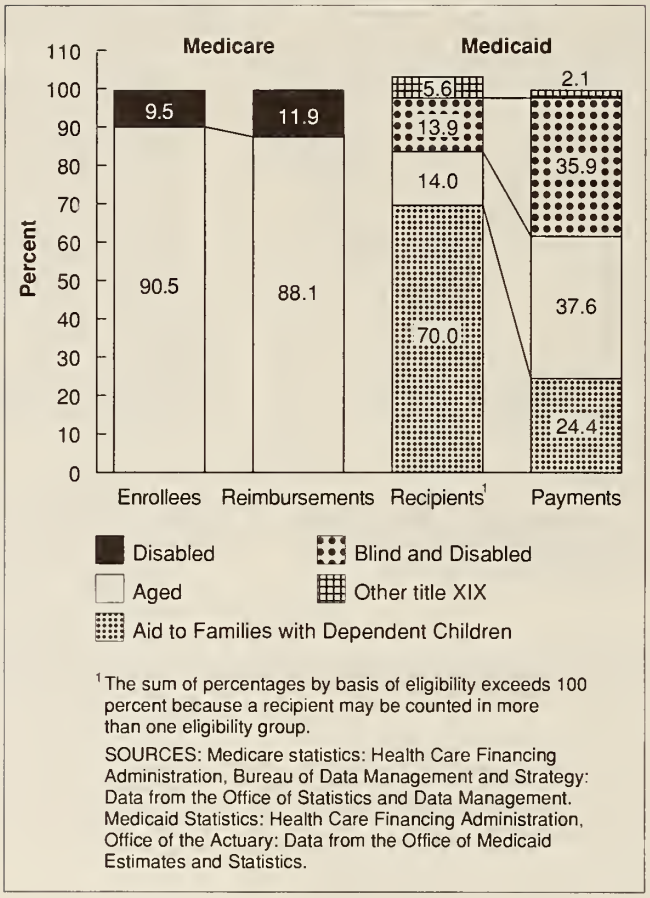
Percent distribution of Medicaid payments, by type of service: Fiscal year 1985



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 1.3

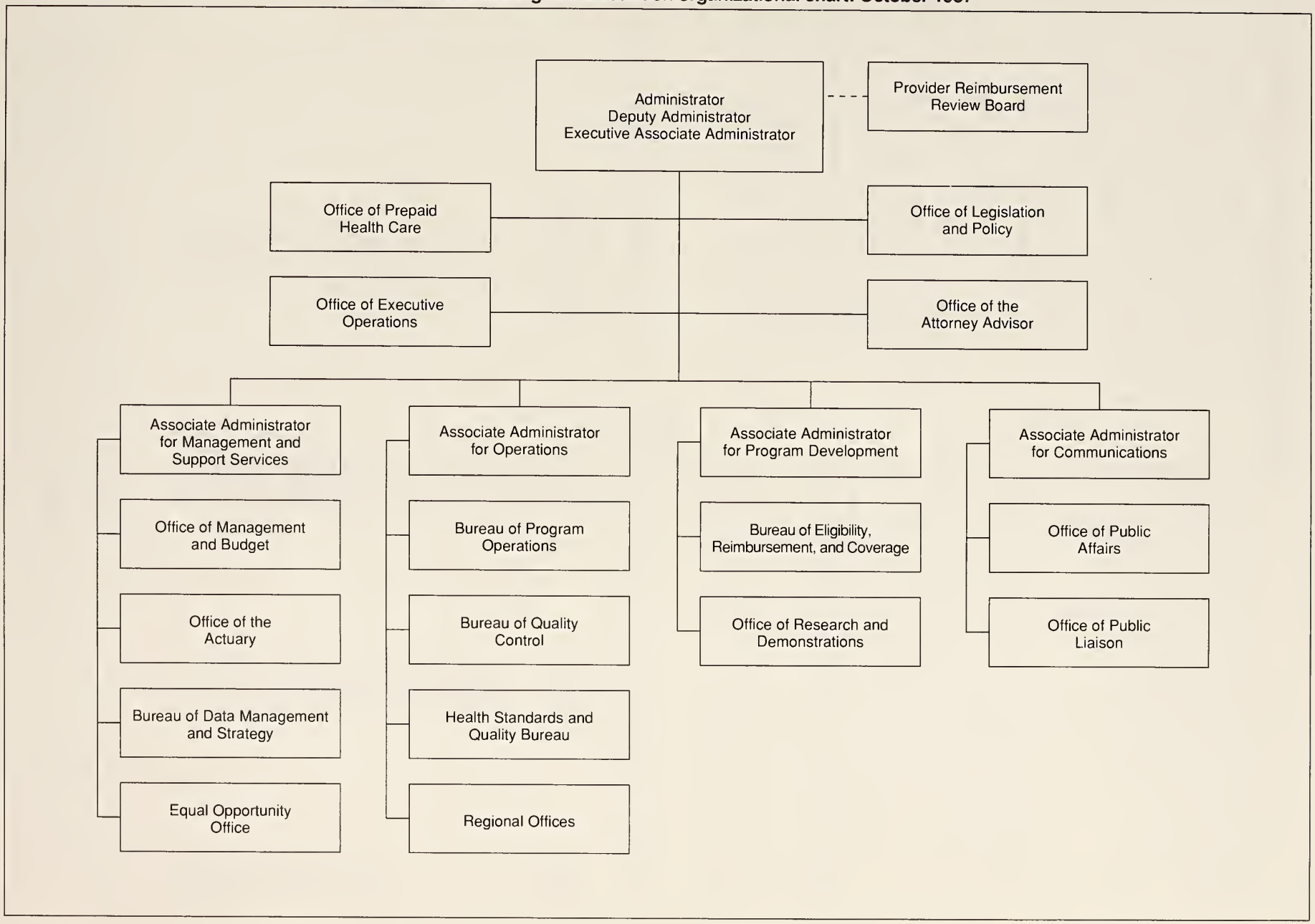
Percent distribution of Medicare enrollees and reimbursements, by type of enrollee, in calendar year 1984 and Medicaid recipients and payments, by basis of eligibility, in fiscal year 1985



[1] The sum of percentages by basis of eligibility exceeds 100 percent because a recipient may be counted in more than one eligibility group.

SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management. Medicaid Statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 1.4
Health Care Financing Administration organizational chart: October 1987


Administrator
Deputy Administrator
Executive Associate Administrator
Provider Reimbursement Review Board
Office of Prepaid Health Care
Office of Legislation and Policy
Office of Executive Operations
Office of the Attorney Advisor
Associate Administrator for Management and Support Services
Office of Management and Budget
Office of the Actuary
Bureau of Data Management and Strategy
Equal Opportunity Office
Associate Administrator for Operations
Bureau of Program Operations
Bureau of Quality Control
Health Standards and Quality Bureau
Regional Offices
Associate Administrator for Program Development
Bureau of Eligibility, Reimbursement, and Coverage
Office of Research and Demonstrations
Associate Administrator for Communications
Office of Public Affairs
Office of Public Liaison

2. Medicare and Medicaid trends

In this chapter, trends in the Medicare and Medicaid programs are reported: the number of Medicare enrollees and Medicaid recipients by basis of eligibility and population characteristics; expenditures, in total and by eligibility category; and hospital inpatient services, physicians' services, and other services financed by the Medicare and Medicaid programs. A time series of Medicare deductibles and coinsurance amounts is presented. The chapter ends with a discussion of Medicare and Medicaid expenditures as related to national personal health care expenditures.

Enrollees and recipients

As shown in Table 2.1, the number of Medicare enrollees increased 2.6 percent per year from 1966 through 1984. (The annual compound rate of growth, ACRG, is expressed as a percent in the tables.) Supplementary medical insurance (SMI) enrollment increased slightly faster than hospital insurance (HI) enrollment. Total enrollment jumped 10 percent from 1972 to 1973, reflecting the extension of Medicare coverage to the disabled by the 1972 Amendments to the Social Security Act. Prior to the 1972 amendments, only persons 65 years of age or over were covered by Medicare.

From fiscal year 1973 to fiscal year 1985, the number of Medicaid recipients (persons who received services paid for by Medicaid) increased 0.9 percent a year.[3] This upward trend included periods of growth and decline (Figure 2.1). In contrast, Medicare enrollment grew continuously from 1966 to 1984.

Medicare enrollees

Data on the number of aged HI and SMI enrollees by age, sex, and race for July 1, 1966 through 1984, are shown in Table 2.2. All demographic groups shown in the table grew in size, with SMI enrollment increasing faster than HI enrollment in each group. For both HI and SMI, enrollment increases were smaller for men than women, for white persons than all other persons, and for the younger age group (65–74 years) than persons 75 years of age or over. The gradual aging of Medicare enrollees has long-term consequences for the Medicare program because older enrollees are relatively

[3] The Medicaid data presented in this report were first compiled in the present format in fiscal year 1973. Previous data were based on reporting categories different from those now used. To avoid erroneous inferences, the data for earlier years are excluded from this report.

Table 2.1

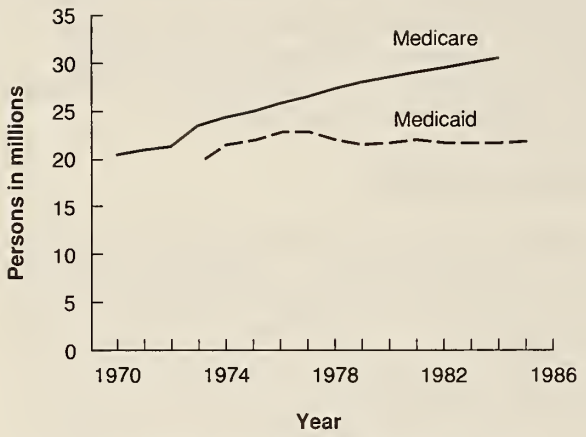
Number of Medicare enrollees by type of coverage and number of Medicaid recipients: 1966–85

Year[1]	Medicare enrollees			Medicaid recipients
	Hospital insurance and/or supplementary medical insurance	Hospital insurance	Supplementary medical insurance	
	Number in thousands			
1966	19,108.8	19,082.5	17,736.0	—
1967	19,521.0	19,493.9	17,893.0	—
1968	19,821.0	19,769.7	18,804.8	—
1969	20,102.7	20,014.2	19,194.7	—
1970	20,490.9	20,361.2	19,584.4	—
1971	20,914.9	20,742.3	19,974.7	—
1972	21,332.1	21,115.3	20,351.3	—
1973	23,545.4	23,301.1	22,490.5	19,622.2
1974	24,201.0	23,924.1	23,166.6	21,462.2
1975	24,958.6	24,640.5	23,904.6	22,006.6
1976	25,662.9	25,312.6	24,614.4	22,814.6
1977	26,457.9	26,093.9	25,363.5	22,831.8
1978	27,164.2	26,777.3	26,074.1	21,964.8
1979	27,858.7	27,459.2	26,757.3	21,520.5
1980	28,478.2	28,066.9	27,399.7	21,604.6
1981	29,010.0	28,589.5	27,941.2	21,979.6
1982	29,494.2	29,069.0	28,412.3	21,603.2
1983	30,026.0	29,587.3	28,974.5	21,554.1
1984	30,455.4	29,996.0	29,415.4	21,607.0
1985	—	—	—	21,808.3
	Percent			
ACRG[2]	2.6	2.5	2.9	0.9

[1] Medicare data are as of July 1 of each calendar year; Medicaid data are as of each fiscal year.
[2] Annual compound rate of growth.

SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 2.1
Number of Medicare enrollees and Medicaid recipients: 1970-85



SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Stastistics and Data Management. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

high users of health care services and raise the reimbursement per enrollee.

The rate of growth in the number of disabled enrollees (Table 2.3) was much greater than that of aged enrollees (Table 2.2). For both HI and SMI, the greatest increase in enrollment among the disabled occurred in the youngest age group, under 35 years. HI and SMI enrollment showed smaller increases for males than females and for white enrollees than all others. Both HI and SMI enrollment of the disabled fell from 1981 to 1984. The decrease among the Medicare disabled reflects the decrease in the number of disabled persons awarded benefits under the disability insurance program.

Medicaid recipients

Trend data on the number of Medicaid recipients by basis of eligibility and maintenance assistance status are presented in Table 2.4. Recipients are divided into two groups: those who receive cash payments as well as Medicaid benefits and those who receive medical

Table 2.2
Number of aged Medicare enrollees, by type of coverage, age, sex, and race: July 1, 1966–84

	Hospital insurance							Supplementary medical insurance						
		Age		Sex		Race[1]			Age		Sex		Race[1]	
Year	Total	65–74 years	75 years or over	Male	Female	White	All other	Total	65–74 years	75 years or over	Male	Female	White	All other
	Number in thousands													
1966	19,082	11,990	7,092	8,133	10,950	17,042	1,445	17,736	11,186	6,550	7,534	10,202	15,938	1,264
1967	19,494	12,116	7,378	8,243	11,251	17,385	1,496	17,893	11,114	6,779	7,547	10,346	16,124	1,245
1968	19,770	12,158	7,611	8,318	11,452	17,632	1,525	18,805	11,561	7,244	7,878	10,927	16,877	1,368
1969	20,014	12,195	7,819	8,396	11,618	17,859	1,558	19,195	11,705	7,490	8,010	11,185	17,229	1,406
1970	20,361	12,316	8,045	8,507	11,855	18,187	1,608	19,584	11,873	7,711	8,132	11,452	17,576	1,472
1971	20,742	12,462	8,280	8,628	12,114	18,582	1,672	19,975	12,050	7,924	8,250	11,724	17,974	1,532
1972	21,115	12,641	8,474	8,744	12,371	18,930	1,693	20,351	12,248	8,104	8,360	11,991	18,325	1,557
1973	21,571	12,911	8,660	8,911	12,660	19,242	1,762	20,921	12,586	8,334	8,569	12,352	18,737	1,636
1974	21,996	13,182	8,814	9,005	12,991	19,601	1,809	21,422	12,925	8,496	8,694	12,727	19,149	1,704
1975	22,472	13,426	9,046	9,168	13,304	19,996	1,870	21,945	13,215	8,730	8,873	13,073	19,575	1,781
1976	22,920	13,691	9,229	9,324	13,596	20,382	1,916	22,446	13,529	8,917	9,047	13,399	19,995	1,845
1977	23,475	13,986	9,488	9,537	13,937	20,857	1,977	22,991	13,830	9,161	9,240	13,751	20,456	1,909
1978	23,984	14,259	9,725	9,728	14,256	21,289	2,036	23,531	14,119	9,412	9,436	14,094	20,906	1,978
1979	24,548	14,582	9,967	9,945	14,604	21,770	2,100	24,098	14,414	9,685	9,645	14,454	21,385	2,046
1980	25,104	14,892	10,210	10,156	14,948	22,244	2,160	24,680	14,726	9,954	9,868	14,813	21,876	2,114
1981	25,591	15,152	10,439	10,340	15,250	22,661	2,210	25,182	14,977	10,205	10,055	15,127	22,298	2,172
1982	26,115	15,386	10,728	10,538	15,577	23,104	2,265	25,707	15,192	10,515	10,250	15,457	22,738	2,231
1983	26,670	15,631	11,040	10,755	15,915	23,575	2,322	26,292	15,450	10,843	10,479	15,813	23,231	2,296
1984	27,112	15,805	11,306	10,920	16,192	23,945	2,374	26,764	15,633	11,131	10,652	16,112	23,619	2,358
	Percent													
ACRG[2]	2.0	1.5	2.6	1.7	2.2	1.9	2.8	2.3	1.9	3.0	1.9	2.6	2.2	3.5

[1] Excludes unknown race.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.3

Number of disabled Medicare enrollees, by age, sex, race, and type of coverage: July 1, 1973–84

Type of coverage and year	Total	Age				Sex		Race[1]	
		Under 35 years	35–44 years	45–54 years	55–64 years	Male	Female	White	All other
Hospital insurance				Number in thousands					
1973	1,730.5	192.4	218.0	438.8	881.4	1,118.8	611.8	1,444.9	253.2
1974	1,928.1	220.2	237.6	481.4	988.9	1,232.1	696.0	1,602.3	287.1
1975	2,168.4	254.3	261.7	530.0	1,122.4	1,380.9	787.5	1,800.9	329.2
1976	2,392.2	288.3	285.8	574.0	1,244.1	1,514.3	877.8	1,983.2	370.9
1977	2,619.4	322.6	310.6	617.3	1,368.9	1,654.2	965.2	2,163.0	415.1
1978	2,793.2	344.8	335.4	646.5	1,466.5	1,763.0	1,030.2	2,299.1	447.8
1979	2,910.8	361.4	356.0	658.0	1,535.3	1,837.4	1,073.4	2,388.1	471.4
1980	2,963.2	371.2	369.5	657.5	1,565.0	1,870.5	1,092.6	2,422.2	486.7
1981	2,999.0	383.5	385.1	654.7	1,575.6	1,896.0	1,102.9	2,442.1	499.9
1982	2,954.2	377.7	386.0	622.2	1,568.4	1,865.2	1,089.0	2,399.6	497.3
1983	2,917.6	379.7	400.1	598.1	1,539.7	1,845.6	1,071.9	2,362.0	498.7
1984	2,884.4	388.2	422.2	584.2	1,489.7	1,830.2	1,054.2	2,325.9	502.2
				Percent					
ACRG[2]	4.8	6.6	6.2	2.6	4.9	4.6	5.1	4.4	6.4
Supplementary medical insurance				Number in thousands					
1973	1,569.9	174.9	194.7	390.2	810.0	1,003.3	566.6	1,307.7	233.4
1974	1,745.0	194.0	211.0	428.0	912.0	1,102.0	643.0	1,446.0	263.1
1975	1,959.2	225.8	232.3	469.2	1,032.0	1,230.6	728.7	1,622.3	300.3
1976	2,168.5	258.3	255.7	510.2	1,144.3	1,352.8	815.7	1,792.6	339.6
1977	2,372.6	290.0	278.8	548.7	1,255.2	1,475.4	897.3	1,954.3	379.3
1978	2,543.2	311.9	303.1	579.2	1,349.0	1,581.8	961.3	2,088.9	411.0
1979	2,658.8	328.6	323.4	592.6	1,414.3	1,655.1	1,003.7	2,176.7	433.9
1980	2,719.2	339.7	337.1	596.3	1,446.1	1,694.6	1,024.7	2,218.2	449.8
1981	2,759.5	352.7	352.3	596.3	1,458.2	1,723.9	1,035.6	2,242.3	463.5
1982	2,705.5	345.8	347.4	561.1	1,451.2	1,687.6	1,017.9	2,192.7	458.7
1983	2,682.4	349.5	362.9	542.7	1,427.4	1,677.4	1,005.0	2,167.3	461.3
1984	2,651.2	358.0	382.3	530.0	1,380.9	1,663.9	987.4	2,134.3	463.8
				Percent					
ACRG[2]	4.9	6.7	6.3	2.8	5.0	4.7	5.2	4.6	6.4

[1] Excludes unknown race.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

assistance only.[4] From fiscal year 1973 to fiscal year 1985, the total number of cash assistance recipients using Medicaid services increased at an average rate of 1.0 percent a year. The number of Medicaid recipients in the aged and blind cash assistance groups decreased during the same period at annual rates of 2.4 and 1.4 percent per year, respectively. Of all cash assistance groups, the highest rate of growth in the number of Medicaid recipients occurred among disabled enrollees. Most of this increase occurred from 1973 to 1977, when the total number of disabled cash recipients increased by more than one-half. The number of Aid to Families with Dependent Children (AFDC) children under age 21, who comprise approximately one-half of all cash assistance Medicaid recipients, grew at an annual rate of 1.1 percent per year.

The number of Medicaid recipients receiving medical assistance only increased at a slightly faster rate than the cash assistance group, 1.4 percent per year. Among recipients of medical assistance only, the number of disabled recipients and adult recipients covered under the AFDC program grew most rapidly, at rates of 4.5 and 8.4 percent per year, respectively. The number of blind recipients of medical assistance only decreased by an annual compound rate of 5.1 percent.

Data on Medicaid recipients in fiscal years 1973–85 are presented by age, sex, and race in Table 2.5. The race of significant numbers of recipients in some reporting States was unknown, so race data should be used with caution. The number of recipients in the group 65 years of age or over decreased at an annual rate of 2.0 percent. The number in all other age groups grew at rates ranging from 0.5 to 4.1 percent per year.

Expenditures

Data on Medicare benefit payments from the trust funds and Medicaid payments are shown in Table 2.6 and Figure 2.2. Total Medicare benefit payments grew at an average annual rate of 16.7 percent from 1967 to 1984. SMI benefit payments increased more rapidly than HI benefit payments. The large increase in total benefit

[4] Data on medically needy recipients, a subgroup of recipients receiving medical assistance only, are available on request for fiscal year 1975 and later years from the Office of the Actuary.

Table 2.4

Number of Medicaid recipients, by maintenance assistance status and basis of eligibility: Fiscal years 1973–85

Year	Cash assistance						Medical assistance only						
		SSI[1]			AFDC[2]			SSI[1]			AFDC[2]		
	Total[3]	Aged	Blind	Disabled	Children under 21 years[4]	Adults	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other title XIX
	Number in thousands												
1973	14,519.9	2,226.9	83.6	1,425.4	7,167.3	3,616.7	5,102.3	1,268.6	17.7	378.7	1,641.4	449.7	1,346.2
1974	15,969.1	2,510.3	99.9	1,810.8	7,820.2	3,727.8	5,147.3	1,191.4	29.2	386.8	1,652.2	562.9	1,324.9
1975	16,678.0	2,416.2	84.6	1,865.8	8,349.3	3,962.1	5,328.6	1,199.1	24.7	489.1	1,248.9	567.0	1,799.9
1976	17,221.9	2,396.7	78.5	2,037.7	8,527.0	4,182.0	5,592.7	1,215.5	18.4	534.5	1,396.6	591.3	1,836.4
1977	17,066.9	2,367.7	76.0	2,172.0	8,359.7	4,091.6	5,764.9	1,267.9	16.3	537.9	1,291.1	693.3	1,958.5
1978	16,423.0	2,133.4	67.2	2,081.9	8,165.3	3,975.2	5,541.8	1,242.4	14.6	554.0	1,210.3	668.0	1,852.5
1979	16,055.9	2,092.5	67.5	2,088.6	7,905.9	3,901.4	5,464.6	1,271.8	11.7	585.1	1,200.5	668.2	1,727.3
1980	16,497.2	2,035.3	76.7	2,186.4	8,114.2	4,093.5	5,390.9	1,404.8	14.9	632.5	1,219.0	783.2	1,499.1
1981	16,871.8	1,952.6	71.1	2,254.9	8,305.9	4,327.5	5,492.9	1,414.0	15.3	737.8	1,274.8	859.7	1,364.3
1982	16,594.1	1,850.7	72.7	2,190.6	8,187.0	4,370.1	5,642.5	1,389.0	11.6	615.7	1,376.5	986.2	1,433.7
1983	16,519.4	1,815.7	66.4	2,201.9	8,079.3	4,494.4	5,855.3	1,556.0	10.6	642.5	1,456.0	1,098.1	1,128.6
1984	16,478.1	1,729.8	69.1	2,197.5	8,156.8	4,429.6	5,990.6	1,508.4	10.0	636.3	1,527.1	1,170.1	1,186.7
1985	16,458.7	1,663.2	70.9	2,294.7	8,155.3	4,329.1	6.023.5	1,398.2	9.5	641.7	1,597.0	1,188.4	1,213.6
	Percent												
ACRG[5]	1.0	−2.4	−1.4	4.0	1.1	1.5	1.4	0.8	−5.1	4.5	−0.2	8.4	−0.9

[1] Supplemental Security Income.
[2] Aid to Families with Dependent Children.
[3] Totals for each year include estimated recipient counts for nonreporting States. The sum of recipients in the maintenance assistance categories exceeds total recipients because recipients who are eligible in more than one category are counted in each category but only once in the total.
[4] Cash assistance to other title XIX recipients was phased out after 1974; title XIX cash assistance data for 1973–74 are included with data for children under 21 years.
[5] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.5

Number of Medicaid recipients, by age, sex, and race: Fiscal years 1973–85

Year	Total	Age				Sex		Race		
		Under 6 years	6–20 years	21–64 years	65 years or over	Male	Female	White	All other	Unknown
	Number in thousands									
1973	19,622.2	2,890.4	5,943.6	6,292.8	4,495.4	7,222.9	12,399.3	—	—	—
1974	21,462.2	3,466.1	6,827.0	7,423.7	3,745.1	7,462.4	13,999.6	—	—	—
1975	22,006.6	3,334.0	7,257.7	7,660.5	3,754.3	7,686.9	14,319.7	8,234.6	6,105.9	7,666.0
1976	22,814.6	3,584.2	7,706.7	7,843.7	3,680.0	7,973.7	14,840.9	8,355.4	6,598.2	7,861.0
1977	22,831.8	3,490.9	7,331.3	8,235.4	3,774.1	8,034.5	14,797.3	8,439.1	6,396.5	7,996.2
1978	21,964.8	3,402.4	7,165.0	7,874.3	3,523.1	7,639.3	14,325.5	8,121.5	6,247.0	7,596.3
1979	21,520.5	3,398.1	6,850.0	7,504.2	3,768.3	7,467.6	14,052.9	8,036.2	7,119.4	6,364.8
1980	21,604.6	4,017.5	6,906.4	7,350.1	3,330.5	7,702.4	13,902.2	7,846.7	6,275.9	7,481.8
1981	21,979.6	4,087.2	7,026.3	7,477.7	3,388.3	7,836.1	14,143.5	7,982.9	6,384.8	7,611.7
1982	21,603.2	3,996.6	6,848.2	6,999.4	3,759.0	7,777.2	13,826.0	8,142.7	6,209.5	7,251.0
1983	21,554.1	3,660.1	6,576.1	7,352.3	3,965.6	7,811.8	13,742.3	9,294.9	8,390.8	3,868.3
1984	21,607.0	4,476.1	6,293.5	7,214.0	3,623.5	7,943.5	13,663.6	9,520.3	9,061.5	3,025.3
1985	21,808.3	4,680.9	6,339.5	7,265.2	3,522.7	7,850.3	13,958.0	11,419.2	8,638.5	1,750.5
	Percent									
ACRG[1]	0.9	4.1	0.5	1.2	−2.0	0.7	1.0	3.3	3.5	−13.7

[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.6

Medicare benefit payments by type of coverage, Medicaid payments by basis of eligibility, and percent change in total from previous year: 1966–85

Year[1]	Medicare benefit payments				Medicaid payments				
		Coverage				Basis of eligibility			
	Total	Hospital insurance	Supplementary medical insurance	Percent change	Total	AFDC[2]	SSI[3]	Other	Percent change
	Amount in millions				Amount in millions				
1966[4]	$1,019	$891	$128	NA	—	—	—	—	—
1967	4,549	3,353	1,197	346.4	—	—	—	—	—
1968	5,697	4,179	1,518	25.2	—	—	—	—	—
1969	6,603	4,739	1,865	15.9	—	—	—	—	—
1970	7,099	5,124	1,975	7.5	—	—	—	—	—
1971	7,868	5,751	2,117	10.8	—	—	—	—	—
1972	8,643	6,318	2,325	9.9	—	—	—	—	—
1973[5]	9,583	7,057	2,526	10.9	$8,640	$2,872	$5,315	$452	NA
1974	12,418	9,099	3,318	29.6	9,983	3,398	6,159	425	15.5
1975	15,588	11,315	4,273	25.5	12,242	4,248	7,503	492	22.6
1976	18,420	13,340	5,080	18.2	14,091	4,719	8,830	542	15.1
1977	21,774	15,737	6,038	18.2	16,239	5,216	10,382	641	15.2
1978	24,934	17,682	7,252	14.5	17,992	5,421	11,929	643	10.8
1979	29,331	20,623	8,708	17.6	20,472	5,905	13,928	638	13.8
1980	35,699	25,064	10,635	21.7	23,311	6,354	16,361	596	13.9
1981	43,455	30,342	13,113	21.7	27,204	7,271	19,381	552	16.7
1982	51,086	35,631	15,455	17.6	29,399	7,567	21,144	689	8.1
1983	57,443	39,337	18,106	12.4	32,391	8,322	23,321	747	10.2
1984	62,918	43,257	19,661	9.5	33,891	8,398	24,793	700	4.6
1985	—	—	—	—	37,508	9,161	27,549	798	10.7
				Percent					
ACRG[6]	16.7	16.2	17.9	NA	13.0	10.1	14.7	4.9	NA

[1] Medicare data are for calendar years; Medicaid data are for fiscal years.
[2] Aid to Families with Dependent Children.
[3] Supplemental Security Income.
[4] July–December only.
[5] Disabled enrollees were covered by Medicare on July 1, 1973.
[6] Annual compound rate of growth. ACRG computed for 1967–84 for Medicare and 1973–85 for Medicaid.

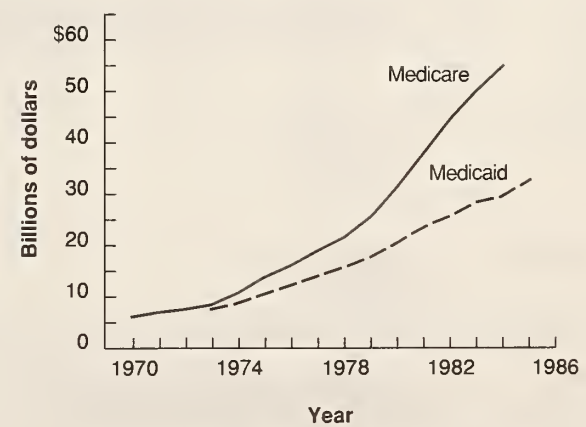
SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates and the Division of Medicaid Estimates and Statistics.

payments from 1973 to 1974, 29.6 percent, reflects the extension of Medicare coverage to the disabled. The entry of the disabled also accelerated the rate of increase in SMI benefit payments, largely because of the rising number of end stage renal disease (ESRD) patients with SMI coverage. This subject is covered in more detail in the section on services to ESRD enrollees.

Medicaid payments also increased, growing at an average annual rate of 13.0 percent from fiscal year 1973 to fiscal year 1985. Payments for those covered by the Supplemental Security Income program grew the fastest. As indicated in Figure 2.2, the rate of increase in Medicare reimbursement historically has been higher than that for Medicaid payments.

Changes over time in the distribution of Medicare reimbursements and Medicaid payments by type of service covered are shown in Figures 2.3 and 2.4. The proportion of total Medicaid payments for inpatient hospital (general and mental hospital) services decreased from 34.8 percent in 1973 to 28.4 percent in 1985. Conversely, the proportion of Medicare reimbursements for inpatient hospital services increased slightly, from 62.7 percent in 1967 to 65.1 percent in 1984. Over the same period, a small decrease (from 28.9 percent in

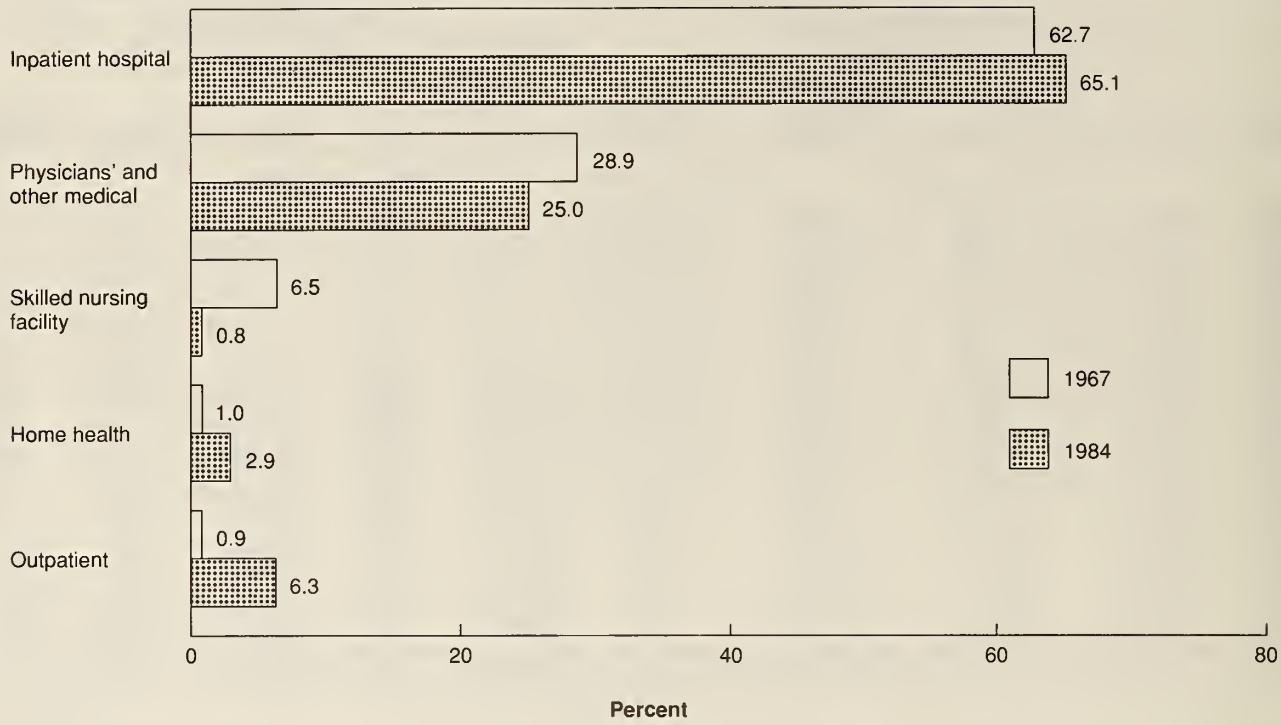
Figure 2.2
Medicare benefit payments and Medicaid payments: 1970-85



SOURCES: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates and the Office of Medicaid Estimates and Statistics.

Figure 2.3

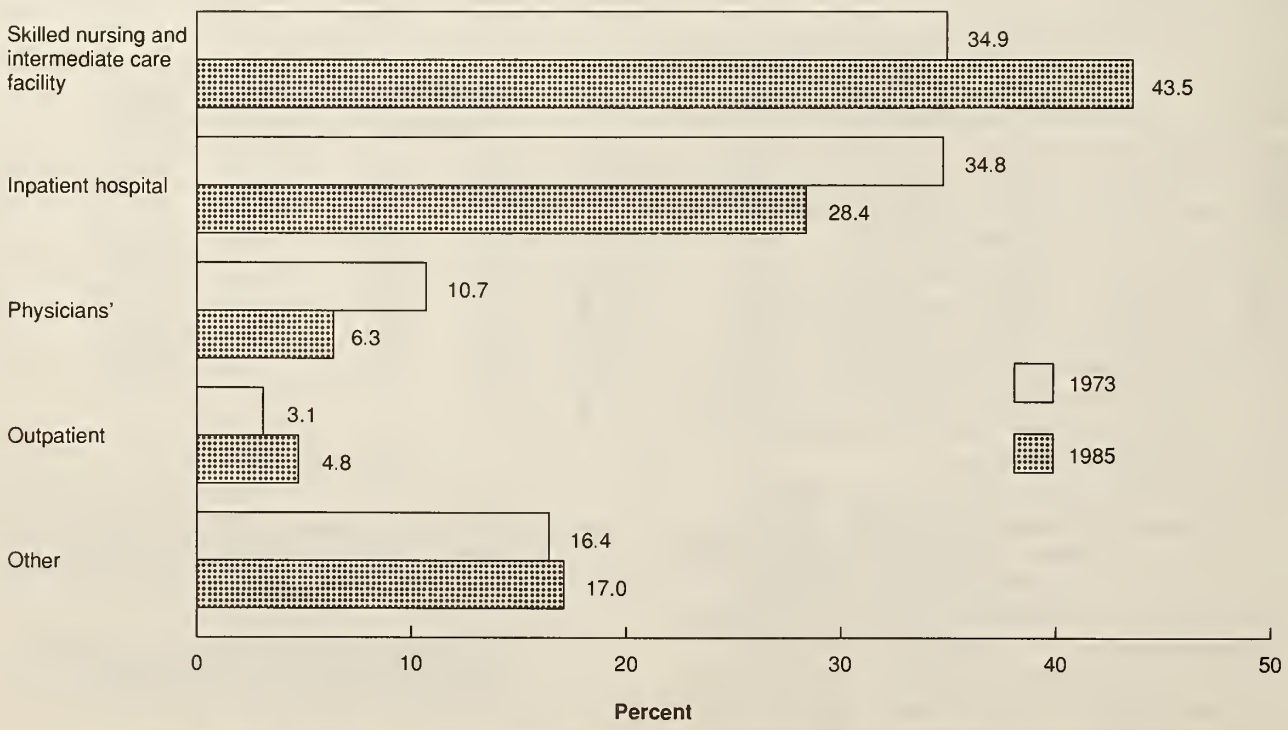
Percent distribution of Medicare reimbursements, by type of service: Fiscal years 1967 and 1984



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.4

Percent distribution of Medicaid payments, by type of service: Fiscal years 1973 and 1985



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

1967 to 25.0 percent in 1984) occurred in the proportion of all Medicare reimbursements made for physicians' and other medical services. Physician payments as a proportion of total Medicaid payments also decreased, from 10.7 percent in 1973 to 6.3 percent in 1985.

Reimbursements for outpatient services as a proportion of all Medicare reimbursements increased sevenfold from 1967 to 1984, from 0.9 percent to 6.3 percent. In part, this increase reflects use of renal dialyses by ESRD patients. Medicaid payments for outpatient services increased at a much slower rate, from 3.1 percent in 1973 to 4.8 percent in 1985. The share of Medicare reimbursements for home health agency services nearly tripled, from 1.0 percent in 1967 to 2.9 percent in 1984. The proportion of Medicare reimbursements for skilled nursing facility services decreased markedly from 1967 (6.5 percent) to 1984 (0.8 percent). In contrast, Medicaid payments for skilled nursing and intermediate care facility services increased from 34.9 percent in 1973 to 43.5 percent in 1985. As shown in these charts, long-term care services account for the largest proportion of total Medicaid payments; in contrast, Medicare is an acute care program.

Medicare reimbursements

Trend data on Medicare reimbursements based on claims paid in a calendar year are shown in Table 2.7 by type of coverage and type of enrollee. Successive increases in reimbursements for each entitlement group resulted in an average annual increase of 16.3 percent in total reimbursements from 1968 to 1984. Some of this increase reflects, of course, the extension of Medicare coverage to disabled persons in 1973. As derived from Table 2.7, reimbursements for the disabled grew much faster than reimbursements for the aged, increasing to 11.9 percent of total reimbursements in 1984 from 8.7 percent in 1974.

As shown in Figure 2.5, a small proportion of enrollees with large medical expenses accounted for a large proportion of Medicare reimbursements for both aged and disabled enrollees. Enrollees reimbursed $15,000 or more represented only 2.3 percent of all aged persons ever enrolled in 1984 but accounted for 31.8 percent of all Medicare reimbursements for the aged. At the other extreme, 35.1 percent of aged enrollees received no reimbursement during the year.

Table 2.7

Medicare reimbursements, by type of coverage and enrollee: Calendar years 1966–84

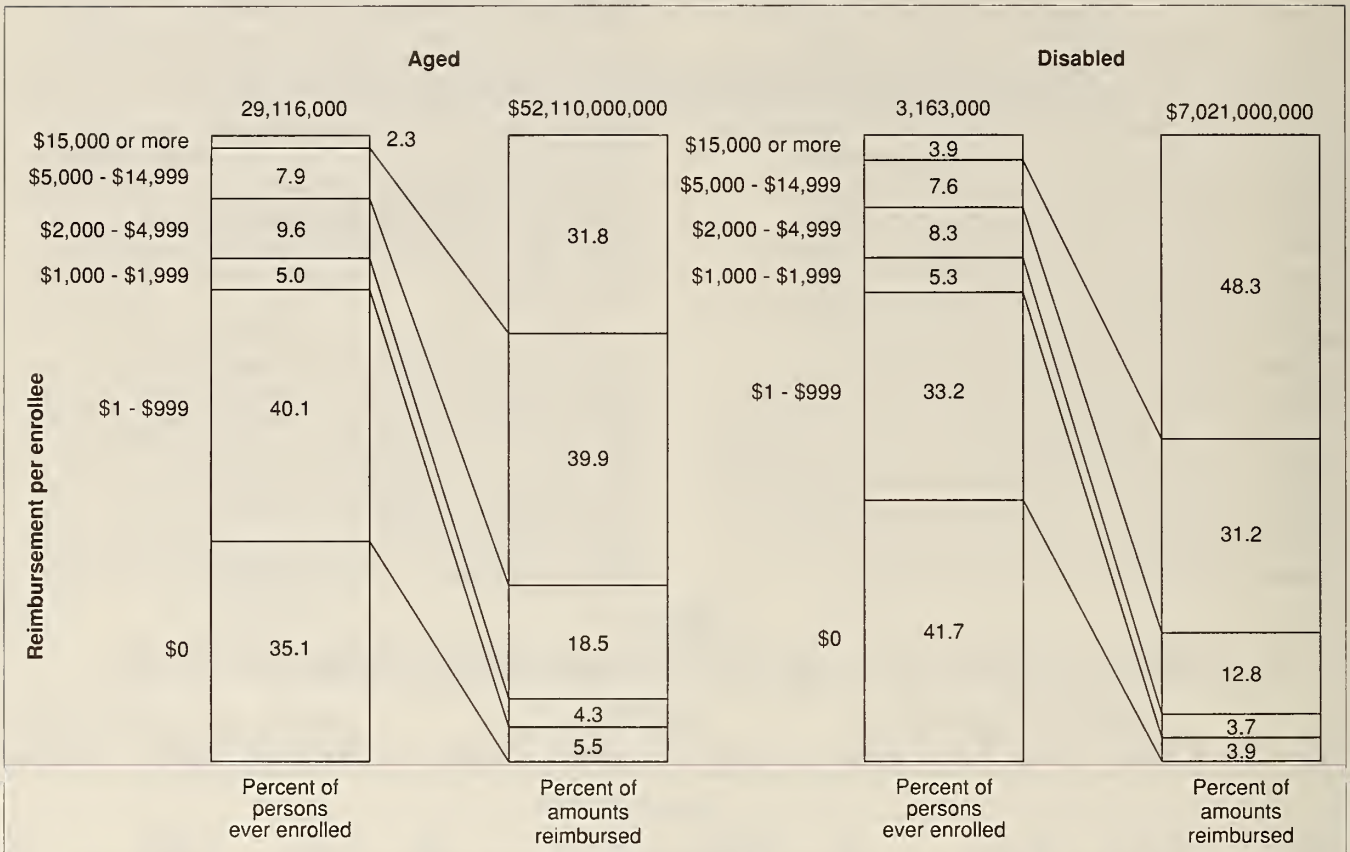
Year	Hospital insurance and supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Total	Aged[1]	Disabled[2]	Total	Aged[1]	Disabled[2]	Total	Aged[1]	Disabled[2]
	Amount in millions								
1966–67[3]	$5,145.2	$5,145.2	NA	$3,839.9	$3,839.9	NA	$1,305.3	$1,305.3	NA
1968	5,289.5	5,289.5	NA	3,766.9	3,766.9	NA	1,522.6	1,522.6	NA
1969	6,267.6	6,267.6	NA	4,597.4	4,597.4	NA	1,670.3	1,670.3	NA
1970	6,572.0	6,572.0	NA	4,740.3	4,740.3	NA	1,831.6	1,831.6	NA
1971	7,354.4	7,354.4	NA	5,358.2	5,358.2	NA	1,996.2	1,996.2	NA
1972	8,019.4	8,019.4	NA	5,835.7	5,835.7	NA	2,183.7	2,183.7	NA
1973	9,251.2	9,038.7	[6]212.6	6,847.9	6,674.3	[6]$173.6	2,403.3	2,364.3	[6]$39.0
1974	11,238.0	10,257.5	980.5	8,118.4	7,454.4	664.0	3,119.6	2,803.1	316.5
1975	14,548.5	13,056.1	1,492.4	10,519.1	9,537.4	981.8	4,029.4	3,518.7	510.6
1976	17,619.0	15,636.5	1,982.5	12,793.9	11,495.8	1,298.1	4,825.1	4,140.7	684.4
1977	20,476.8	18,014.7	2,462.1	14,709.9	13,116.3	1,593.6	5,766.9	4,898.4	868.5
1978	23,542.7	20,579.1	2,963.6	16,630.3	14,740.7	1,889.7	6,912.4	5,838.4	1,073.9
1979	27,699.1	24,005.0	3,694.1	19,257.9	16,940.4	2,317.4	8,441.2	7,064.5	1,376.7
1980	33,724.7	29,224.2	4,500.5	23,194.2	20,404.1	2,790.1	10,530.5	8,820.1	1,710.4
1981	39,918.4	36,614.0	5,304.4	27,486.4	24,180.5	3,305.9	12,432.0	10,433.5	1,998.5
1982	48,134.3	41,786.8	6,347.4	33,332.8	29,360.3	3,972.5	14,801.5	12,426.5	2,374.9
1983	53,437.9	46,726.8	6,711.1	36,313.6	32,140.6	4,173.0	17,124.4	14,586.2	2,538.2
1984[4]	59,132.2	52,118.1	7,014.1	40,607.5	36,083.8	4,523.7	18,524.7	16,034.3	2,490.4
	Percent								
ACRG[5]	16.3	15.4	21.7	16.0	15.2	21.2	16.9	15.9	22.9

[1] For all enrollees 65 years of age or over, including those with end stage renal disease.
[2] For all enrollees under 65 years of age, including those with end stage renal disease. Disabled enrollees were not covered under Medicare until July 1, 1973.
[3] July 1966 through December 1967.
[4] Hospital insurance reimbursement amounts are based on expenditures reported on Health Care Financing Administration (HCFA) billing form HCFA–1450 plus prospective payment system short–stay hospital inpatient passthrough expenditures reported on the HCFA intermediary benefit payment report.
[5] Annual compound rate of growth. ACRG computed for 1968–84 for the aged and 1974–84 for the disabled.
[6] Represents reimbursements for last 6 months of 1973, recorded on a claims–approved basis.

NOTE: Reimbursements, except those for the disabled in 1973, are amounts paid in a calendar year. Reimbursements are not adjusted for claims paid after data were compiled. Reimbursement data differ from data on benefit payments shown in Table 2.6, which include both interim reimbursements and retroactive adjustments made to institutional providers.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Figure 2.5
Percent distribution of aged and disabled Medicare enrollees and reimbursements per enrollee: Calender year 1984



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

(Persons having no reimbursement are those not having covered Medicare charges, not exceeding Medicare deductibles, exceeding deductibles but not filing claims, or receiving covered services without charge.) Another 40.1 percent of aged enrollees received less than $1,000 in reimbursements.

An even more graphic example of how health insurance spreads the risk of illness is provided by comparable figures for the disabled. Although representing only 3.9 percent of all disabled enrollees, those in the group reimbursed $15,000 or more accounted for 48.3 percent of all Medicare reimbursements for disabled enrollees. "High-cost" users account for a larger share of reimbursements in the disabled group than in the aged group, partly because of the significantly greater proportion of ESRD patients among disabled enrollees. Another 41.7 percent of the disabled received no reimbursement.

Medicaid payments

As shown in Table 2.8, Medicaid payments grew the fastest for services provided to the disabled in both maintenance assistance groups. Payments for the disabled who received only medical assistance increased at an average rate of 18.4 percent, and payments for the disabled who received cash assistance increased at a rate of 16.1 percent. The slowest rate of increase occurred for other title XIX recipients and for AFDC children under 21 years of age not receiving cash assistance, with average rates of growth of 4.9 and 6.2 percent, respectively.

Trends in Medicaid payments for long-term care, inpatient hospital services, and all other Medicaid services are shown in Figure 2.6. Payments for long-term care services increased steadily from fiscal year 1973 to fiscal year 1985. Inpatient hospital services and the remaining Medicaid services also increased, but less rapidly.

Medicaid expenditures by age, sex, and race of recipients are reported in Table 2.9. As with Table 2.5, some States did not report recipients' race. From 1973 to 1985, variations in the growth of expenditures by age ranged from an annual average of 12.4 percent for persons 21-64 years of age to 15.0 percent for children under age 6. Increases in payments on behalf of male recipients were similar to those for female recipients (13.3 and 12.9 percent, respectively).

As with Medicare, a small number of recipients consume a disproportionate share of Medicaid payments. The share of total recipients and total payments accounted for by each of five eligibility groups is shown

Table 2.8

Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal years 1973–85

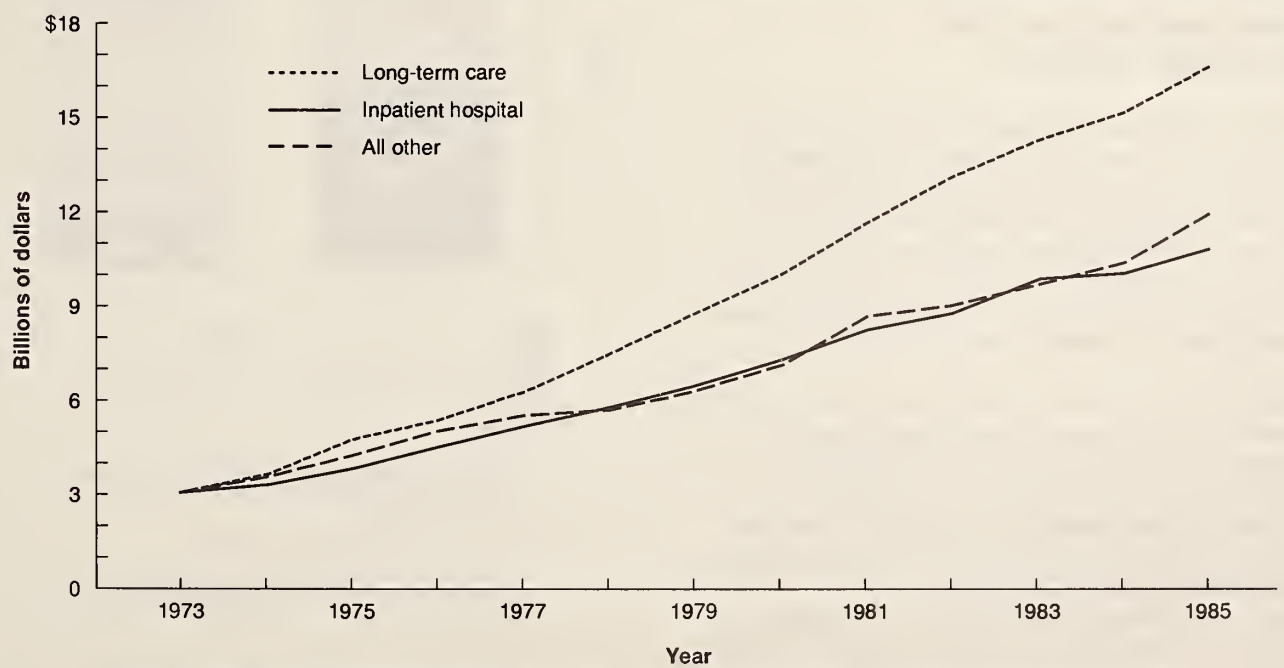
Year	Cash assistance						Medical assistance only						
		SSI[1]			AFDC[2]			SSI[1]			AFDC[2]		
	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other title XIX[4]
	Amount in millions												
1973	$4,693.5	$985.0	$46.4	$1,335.6	$1,048.7	$1,277.8	$3,947.4	$2,250.5	$18.5	$680.5	$377.6	$168.3	$452.0
1974	5,603.9	1,177.5	54.5	1,605.2	1,319.4	1,447.3	4,378.8	2,513.7	25.3	783.1	374.6	257.1	425.0
1975	7,188.3	1,340.9	60.7	2,041.6	1,850.5	1,894.7	5,054.0	3,016.9	32.2	1,010.6	335.6	167.0	491.6
1976	8,154.4	1,448.2	60.4	2,486.3	2,076.1	2,083.3	5,936.3	3,461.8	35.5	1,337.6	354.5	204.9	541.9
1977[5]	9,576.6	1,707.6	75.4	3,189.5	2,246.0	2,358.1	6,662.3	3,791.0	40.7	1,577.8	364.3	247.9	640.7
1978[5]	10,160.0	1,799.0	74.4	3,431.5	2,439.5	2,415.5	7,832.5	4,509.4	41.2	2,073.2	308.9	257.2	642.6
1979	11,281.3	1,879.4	76.0	4,020.2	2,567.1	2,738.6	9,190.4	5,166.6	32.4	2,753.8	317.3	282.2	638.2
1980	12,344.1	2,196.4	87.6	4,479.1	2,698.4	2,882.6	10,966.7	6,542.8	36.8	3,017.8	424.3	348.9	596.2
1981	14,534.2	2,480.2	108.5	5,615.7	3,002.2	3,327.6	12,670.1	7,445.9	45.5	3,685.1	506.1	435.0	552.5
1982	15,861.6	2,705.3	120.5	6,468.0	2,978.5	3,589.3	13,537.8	8,033.8	51.9	3,764.7	495.0	503.8	688.5
1983	17,112.1	3,003.9	132.7	6,866.1	3,256.0	3,853.2	15,278.9	8,950.0	50.5	4,318.1	579.6	633.3	747.4
1984	17,564.1	3,192.4	151.1	7,092.1	3,377.2	3,751.3	16,326.9	9,623.0	67.8	4,666.3	601.3	668.5	700.0
1985	19,316.2	3,510.0	173.2	8,036.5	3,639.8	3,956.8	18,191.4	10,586.3	76.2	5,166.3	774.5	789.6	798.4
	Percent												
ACRG[6]	12.5	11.2	11.6	16.1	10.9	9.9	13.6	13.8	12.5	18.4	6.2	13.7	4.9

[1] Supplemental Security Income.
[2] Aid to Families with Dependent Children.
[3] Totals for each year include estimated payments for nonreporting States. Payments by basis of eligibility may not sum to total because of rounding.
[4] Cash assistance to other title XIX recipients was phased out after 1974; title XIX cash assistance data for 1973–74 are included with data for other title XIX, medical assistance only.
[5] Data for 1977 and 1978 have been adjusted to distribute small amounts of payments on behalf of persons whose basis of eligibility was unknown.
[6] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 2.6

Medicaid payments for long-term care, inpatient hospital, and all other services: Fiscal years 1973-85



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.9

Medicaid payments, by age, sex, and race of recipient: Fiscal years 1973–85

Year	Total	Age				Sex		Race		
		Under 6 years	6–20 years	21–64 years	65 years or over	Male	Female	White	All other	Unknown
		Amount in millions								
1973	$8,640	$537.4	$1,067.9	$3,696.2	$3,338.5	$2,886.6	$5,753.4	—	—	—
1974	9,983	601.0	1,335.7	4,140.0	3,906.3	3,235.5	6,747.5	—	—	—
1975	12,242	717.4	1,712.7	5,021.7	4,790.3	3,908.8	8,333.2	$5,920.0	$2,635.5	$3,686.4
1976	14,091	880.7	2,046.0	5,837.8	5,326.4	4,535.9	9,555.1	6,645.5	3,122.0	4,323.5
1977	16,239	1,000.4	2,459.2	6,865.8	5,912.7	5,274.5	10,964.5	8,134.4	3,546.1	4,558.6
1978	17,992	1,149.7	2,526.1	7,544.0	6,772.2	5,919.4	12,072.6	9,053.0	4,038.2	4,900.8
1979	20,472	1,244.5	2,712.3	8,522.0	7,993.6	6,677.9	13,794.1	11,052.0	5,271.5	4,148.5
1980	23,311	1,736.0	3,285.0	9,872.6	8,417.3	7,802.2	15,508.9	12,360.1	4,896.4	6,054.5
1981	27,204	2,040.3	3,318.9	11,099.2	10,745.5	9,113.3	18,090.7	18,634.7	6,257.0	2,312.3
1982	29,399	2,205.0	3,586.6	11,994.7	11,612.6	9,848.7	19,550.3	20,138.3	6,761.8	2,498.9
1983	32,391	1,904.6	4,062.1	13,265.7	13,158.5	11,001.9	21,389.1	19,618.8	7,408.9	5,363.3
1984	33,891	2,485.8	4,043.1	13,739.6	13,622.4	11,713.6	22,177.4	22,545.8	7,971.3	3,373.9
1985	37,508	2,875.5	4,410.8	15,059.6	15,161.7	12,868.1	24,639.5	26,796.5	10,217.6	493.6
		Percent								
ACRG[1]	13.0	15.0	12.5	12.4	13.4	13.3	12.9	16.3	14.5	– 18.2

[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

in Figure 2.7. In fiscal year 1985, the aged accounted for 14.0 percent of all recipients and 37.6 percent of all payments. Similarly, the blind and disabled accounted for only 13.9 percent of all recipients but 35.9 percent of all payments. Together, the aged, blind, and disabled accounted for 27.9 percent of all recipients and 73.5 percent of all payments. At the opposite end of the spectrum are children in AFDC families, who accounted for 44.7 percent of all recipients but only 11.8 percent of all payments.

Short-stay hospital and physicians' services

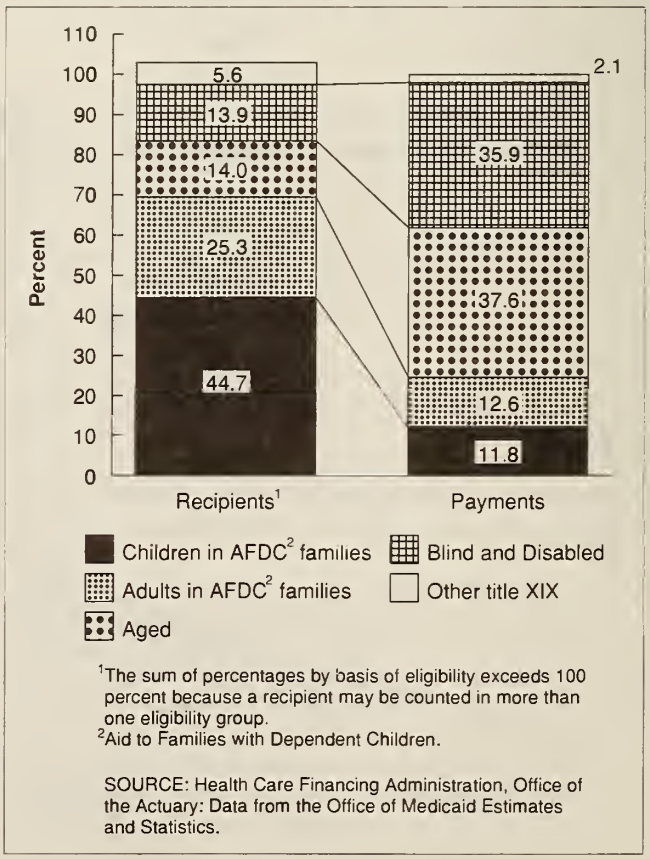
Data on Medicare and Medicaid short-stay inpatient hospital use are presented in Table 2.10. Discharges, covered days of care, reimbursements for Medicare enrollees, and payments for Medicaid recipients are included. Disabled Medicare enrollees exhibited the highest rates of growth in discharges, days of care, and reimbursements. This reflects the rapid rate of increase in enrollment by disabled persons in the 1970's (Table 2.3).

Days of care for disabled Medicare enrollees grew 5.0 percent per year. Days of care for aged Medicare enrollees grew much more slowly, 1.3 percent per year. For short-stay hospital services, growth rates of Medicare reimbursements for the aged (15.9 percent) and the disabled (21.6 percent) were higher than those of Medicaid payments (11.1 percent).

Data on Medicare reimbursements and Medicaid payments for physicians' services are reported in Table 2.11. Like inpatient hospital services, reimbursements for physicians' services grew the fastest for disabled Medicare enrollees, 22.3 percent a year from 1974 to 1984. Medicaid payments for physicians' services grew the slowest, 8.1 percent a year from 1973 to 1985.

Figure 2.7

Percent distribution of Medicaid recipients and payments, by basis of eligibility: Fiscal year 1985



[1]The sum of percentages by basis of eligibility exceeds 100 percent because a recipient may be counted in more than one eligibility group.
[2]Aid to Families with Dependent Children.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.10

Inpatient use of short-stay hospitals under Medicare and general hospitals under Medicaid: 1967–85

Year	Discharges			Covered days of care			Medicare reimbursements		
	Medicare			Medicare[1]					
	Aged	Disabled	Medicaid[2]	Aged	Disabled	Medicaid[2]	Aged	Disabled	Medicaid payments
	Number in thousands						Amount in millions		
1967	5,228	NA	—	68,487	NA	—	$2,760	NA	—
1968	5,641	NA	—	75,589	NA	—	3,509	NA	—
1969	5,852	NA	—	77,246	NA	—	4,085	NA	—
1970	5,951	NA	—	75,578	NA	—	4,481	NA	—
1971	6,090	NA	—	74,298	NA	—	5,036	NA	—
1972	6,380	NA	—	75,284	NA	—	5,576	NA	—
1973	6,751	—	—	77,637	—	—	6,245	—	$2,660
1974	7,033	604	—	79,770	6,378	—	7,209	$621	2,887
1975	7,285	724	3,031	80,135	7,370	22,941	8,859	876	3,374
1976	7,607	863	3,287	82,916	8,661	14,935	10,589	1,183	3,904
1977	7,850	969	3,390	85,471	9,827	25,661	12,455	1,520	4,562
1978	8,133	1,060	3,708	87,033	10,581	25,521	14,182	1,834	4,992
1979	8,478	1,164	3,546	89,075	11,446	21,936	16,251	2,212	5,655
1980	9,051	1,228	3,203	94,422	12,090	24,089	19,460	2,639	6,412
1981	9,376	1,266	3,404	95,065	12,212	26,468	22,812	3,097	7,194
1982	9,913	1,310	2,915	98,268	12,389	21,552	27,223	3,642	7,670
1983	10,292	1,321	3,291	98,807	12,283	22,561	30,966	4,068	8,813
1984	9,927	1,222	3,414	85,369	10,386	23,185	[3]34,086	[3]4,390	8,848
1985	—	—	3,615	—	—	29,562	—	—	9,453
				Percent					
ACRG[4]	3.8	7.3	1.8	1.3	5.0	2.6	15.9	21.6	11.1

1 Days of care covered by Medicare; covered days constitute more than 95 percent of total days of care.

2 Data for New York State are excluded from discharges and days of care for years prior to 1981.

3 Includes estimates of prospective payment system passthrough expenditures as reported in the intermediary hospital payment report of the Health Care Financing Administration.

4 Annual compound rate of growth.

NOTES: Medicare data are for calendar years; Medicaid data are for fiscal years. Discharge figures for 1984 differ from those in Table 3.12 because they were derived from different data sources and different processing cutoff dates.

SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.11

Medicare reimbursements for physicians' and other medical services and Medicaid payments for physicians' services: 1966–85

Year	Medicare reimbursements[1] Aged	Medicare reimbursements[1] Disabled	Medicaid payments
	Amount in millions		
1966[2]	$431.0	NA	—
1967	1,223.8	NA	—
1968	1,437.0	NA	—
1969	1,609.0	NA	—
1970	—	NA	—
1971	1,847.7	NA	—
1972	2,028.8	NA	—
1973	2,112.0	—	$925.9
1974	2,534.0	$206.2	1,083.4
1975	3,050.0	295.2	1,225.1
1976	3,633.0	389.1	1,368.9
1977	4,177.0	481.5	1,504.7
1978	5,145.0	556.5	1,554.4
1979	6,045.0	809.7	1,635.2
1980	7,361.4	996.9	1,874.6
1981	8,688.5	1,198.9	2,101.4
1982	10,310.8	1,671.4	2,085.5
1983	12,105.1	1,555.4	2,174.6
1984	13,218.0	1,548.9	2,220.4
1985	—	—	2,345.6
	Percent		
ACRG[3]	15.0[4]	22.3	8.1

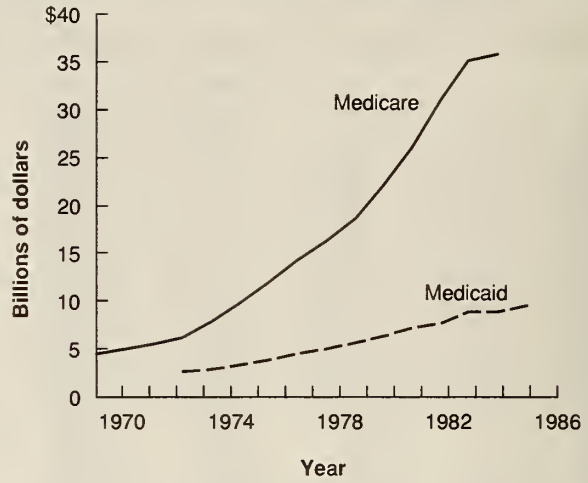
[1] Reimbursements for physicians' services, ambulance services, independent laboratory services, durable medical equipment, and prosthetic devices are included. Therefore, these are not directly comparable with Medicaid payments, which cover only physicians' services.
[2] July–December only.
[3] Annual compound rate of growth.
[4] ACRG computed for 1967–84 only.

NOTES: Medicare data are for calendar years; Medicaid data are for fiscal years.

SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 2.8

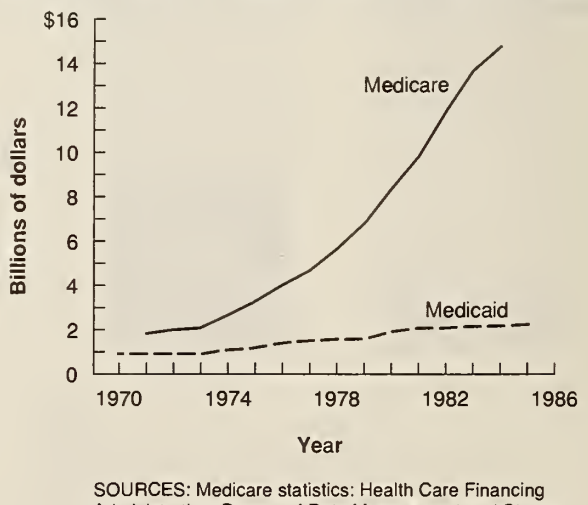
Medicare reimbursements and Medicaid payments for short-stay hospital services: 1970-85



SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management. Medicaid Statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 2.9

Medicare reimbursements for physicians' and other medical services and Medicaid payments for physicians' services: 1970-85



SOURCES: Medicare statistics: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

These trends in Medicare reimbursements and Medicaid payments for short-stay hospital and physicians' services are displayed in Figures 2.8 and 2.9. As shown in each figure, Medicaid payments have been growing more slowly than Medicare reimbursements in recent years.

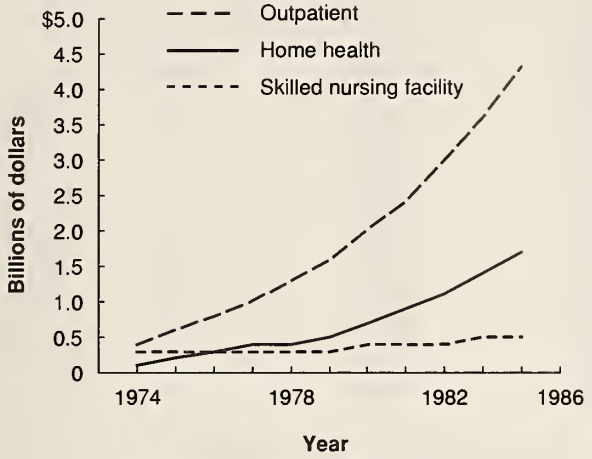
Selected services

Medicare services

Medicare reimbursement trends for skilled nursing care, outpatient services, and home health services are shown in Figure 2.10. The trend line for outpatient care graphically illustrates the sharp increase in reimbursements that occurred after the entry of disabled and ESRD enrollees in 1973. More detailed information on these trends is presented in Tables 2.12, 2.13, and 2.14.

Figure 2.10

Medicare reimbursements for selected services: Calender years 1974-84



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Skilled nursing facility services

Data on the use of and reimbursement for skilled nursing facility (SNF) services are presented in Table 2.12. The data are based on bills for services incurred in a calendar year. Covered days of care for the aged decreased at an average annual rate of 4.2 percent from 1969 to 1984. The decline in the early 1970's resulted from administrative limitations started in 1969 on the Medicare SNF benefit, which, by law, is targeted to enrollees requiring skilled nursing services but not custodial care. In 1984, the disabled accounted for only 3.3 percent of total Medicare-covered days in SNF's. From 1974 (the first year of coverage) to 1984, the number of covered days of care used by the disabled increased at an annual rate of 1.1 percent.

Among the aged, the decline in covered days of care resulted in reimbursement declines from 1969 to 1972; only in 1973 did reimbursements begin to rise. SNF reimbursements for the aged rose at an average annual rate of 2.4 percent during the period 1969–84. In contrast, reimbursements for the disabled rose at an average annual rate of 7.2 percent during the period 1974–84.

Table 2.12

Medicare-covered days of care, covered charges, and reimbursements for skilled nursing facility services, by type of enrollee: Calendar years 1969–84

Year	Covered days of care		Covered charges		Reimbursements	
	Aged	Disabled	Aged	Disabled	Aged	Disabled
	Number in thousands		Amount in millions			
1969	17,572.5	NA	$432.2	NA	$335.0	NA
1970	10,697.1	NA	295.1	NA	225.6	NA
1971	7,481.1	NA	229.9	NA	178.7	NA
1972	6,628.0	NA	212.1	NA	164.1	NA
1973[1]	8,523.0	106.4	278.1	$4.0	209.8	$2.9
1974	8,687.9	277.0	322.9	11.8	237.6	8.3
1975	8,584.7	289.1	405.5	14.8	251.5	9.6
1976	9,406.7	316.6	448.7	17.6	293.5	11.2
1977	9,296.9	334.8	478.5	20.0	301.0	12.3
1978	8,764.5	320.8	500.5	21.1	307.7	12.7
1979	8,292.4	322.3	531.8	23.5	320.7	13.8
1980	8,394.4	318.0	597.3	25.5	352.7	14.4
1981	8,349.7	308.7	674.2	28.6	390.2	15.7
1982	8,519.2	294.7	776.1	30.5	421.1	15.7
1983	8,957.2	302.8	878.4	33.4	449.7	15.9
1984	9,179.3	309.1	994.8	37.6	475.8	16.6
			Percent			
ACRG[2]	−4.2	[3]1.1	5.7	[3]12.3	2.4	[3]7.2

[1] July–December only for disabled enrollees. Disabled enrollees were not covered by Medicare until July 1, 1973.
[2] Annual compound rate of growth.
[3] ACRG computed for 1974–84 only.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.13

Medicare reimbursements for outpatient services, by type of enrollee: Calendar years 1966–84

Year	Aged	Disabled
	Amount in millions	
1966[1]	$38.3	NA
1967	56.7	NA
1968	78.6	NA
1969	103.1	NA
1970	—	NA
1971	124.5	NA
1972	148.2	NA
1973	179.2	—
1974	252.5	$145.3
1975	374.4	221.2
1976	516.2	308.8
1977	649.0	391.7
1978	798.0	480.4
1979	1,001.4	587.9
1980	1,276.8	710.1
1981	1,597.2	817.3
1982	2,025.4	949.8
1983	2,603.6	1,007.3
1984	3,258.6	1,048.3
	Percent	
ACRG[2]	[3]26.9	21.8

[1] July–December only.
[2] Annual compound rate of growth.
[3] ACRG computed for 1967–84 only.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 2.14

Medicare visits and reimbursements for home health services: Calendar years 1969–84

Year	Visits in thousands	Reimbursements in millions
1969	8,500	$78.1
1970	6,000	61.5
1971	4,800	56.8
1972	5,200	65.9
1973	6,400	92.9
1974	8,200	144.3
1975	10,900	217.0
1976	13,500	294.6
1977	15,600	366.5
1978	17,100	426.9
1979	20,000	542.1
1980	22,600	665.7
1981	26,200	859.6
1982	31,400	1,121.0
1983	37,600	1,426.6
1984	41,300	1,701.4
	Percent	
ACRG[1]	11.1	22.8

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Outpatient services

Reimbursements for outpatient care are shown in Table 2.13 and Figure 2.10. Among aged and disabled enrollees combined, outpatient reimbursements grew more rapidly than reimbursements for any other service (as derived from data shown in this chapter). The disabled accounted for nearly one-quarter of outpatient reimbursements, reflecting the impact of the ESRD population on the SMI program.

Home health services

Data on the use of and reimbursements for home health agency (HHA) services for the period 1969–84 are presented in Table 2.14. The rapid increase in visits and reimbursements reflects the implementation of the Omnibus Budget Reconciliation Act of 1980, which improved HHA benefits effective July 1981. The act provided for unlimited HHA visits for enrollees having HI and eliminated the 3-day prior hospitalization requirement to receive services. For the relatively few enrollees with SMI but no HI coverage, the act provided unlimited visits and eliminated the need to meet the SMI deductible before Medicare paid for services.

Services to ESRD enrollees

In Table 2.15, information is presented on reimbursements, enrollment, and per capita reimbursements for enrollees with end stage renal disease during 1974–84.

More information on Medicare coverage can be found in Eggers (1984). In 1974, the first full year of coverage of ESRD patients, total Medicare reimbursements for the ESRD program were $240 million. By 1984, reimbursements had risen to $2,090 million, nearly nine times the amount in 1974, or an annual growth rate of 24.2 percent. However, the rate of growth has slowed considerably in recent years. From 1974 to 1975, the rate of growth was 54 percent. By the most recent time period for which data are available, 1983–84, the growth had slowed to 8.9 percent.

This pattern of growth in reimbursements is largely caused by the growth in the ESRD population. There were 16,000 ESRD enrollees in 1974. By 1984, this total was 94,100, nearly six times as great. Enrollment increases were also greatest in the early years of the program. Although the overall annual growth rate was 19.4 percent, the rate was 41.9 percent from 1974 to 1975 and only 10.7 percent from 1983 to 1984.

The growth rate in ESRD enrollees reflects the unique nature of this Medicare population. Before Medicare covered ESRD patients, most people with ESRD died because of lack of funding for the expensive dialysis maintenance therapy or for transplantation operations. Thus, in July 1973, when the ESRD program began, it mainly served people whose onset of ESRD occurred in 1973. In 1974, the program served people whose ESRD began in 1974 plus survivors whose treatment began in 1973. In 1975, new ESRD patients were added to cohorts from the two previous years, and so on. As enrollment has grown, the number of deaths among the carryover population has begun to approach the number of new entries because annual mortality, even with dialysis, is about 20 percent. Thus, the overall growth rate has slowed considerably.

Table 2.15

Medicare reimbursements, enrollees, and reimbursements per enrollee for persons with end stage renal disease: Calendar years 1974–84

Year	Reimbursements		Enrollees[1]		Reimbursement per enrollee	
	Amount in millions	Percent change	Number in thousands	Percent change	Amount	Percent change
1974	$240	NA	16.0	NA	$15,000	NA
1975	370	54.2	22.7	41.9	16,300	8.7
1976	530	43.2	28.9	27.3	18,300	12.3
1977	660	24.5	34.8	20.4	19,000	3.8
1978	820	24.2	43.1	23.9	19,000	0.0
1979	1,040	26.8	51.8	20.2	20,100	5.8
1980	1,290	24.0	60.0	15.8	21,500	7.0
1981	1,530	18.6	67.8	13.0	22,600	5.1
1982	1,720	12.4	75.9	11.9	22,700	0.4
1983	1,920	11.6	85.0	12.0	22,600	−0.4
1984	2,090	8.9	94.1	10.7	22,200	−1.8
				Percent		
ACRG[2]	24.2	NA	19.4	NA	4.0	NA

[1] Includes enrollees entitled to Medicare benefits as aged or disabled persons and persons entitled by the provisions of Section 299I of Public Law 92–603 as "renal only."
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the End Stage Renal Disease Archival Reimbursement Abstract.

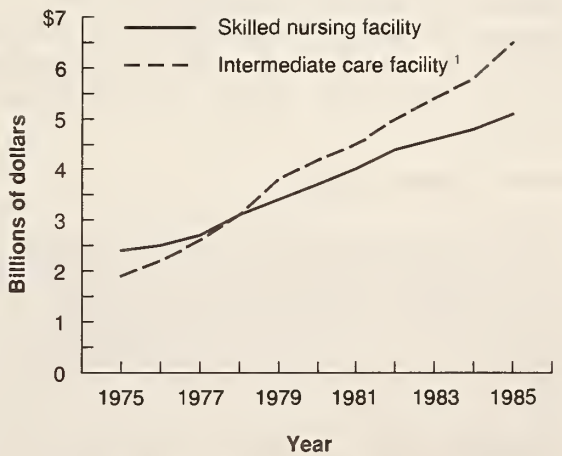
Reimbursements per ESRD enrollee rose from $15,000 in 1974 to $22,200 in 1984. The annual growth rate of only 4.0 percent results largely from a cap in the allowed charge per dialysis since the program began. Since the ESRD program's inception, charges for renal dialysis have generally been held to a $138 maximum per treatment ($110 in reimbursements). As directed by the Omnibus Budget Reconciliation Act of 1981, effective August 1, 1983, HCFA lowered dialysis rates to $131 per treatment for hospital-based facilities and $127 per treatment for freestanding facilities. Thus, the accelerating rate of SMI reimbursements among the disabled primarily reflects increases in the number of ESRD patients rather than increases in reimbursement per patient. Dialysis reimbursements amount to about 50 percent of reimbursements for ESRD patients. The remaining 50 percent is mostly for inpatient hospital care and physicians' services, which have not been subject to a reimbursement cap. A second factor limiting the growth of the ESRD program is the increasing success of transplantation. Patients with a functioning kidney graft incur considerably lower medical expenses than patients on dialysis. In 1978, only 11 percent of the Medicare ESRD population had a functioning kidney graft. By 1985, because of greater numbers of transplants and a greater transplant success rate, 19 percent had a functioning graft.

Parceling out the growth in total ESRD reimbursements into the two components of enrollment and per capita reimbursements shows that 83 percent of the growth is caused by the increase in the enrolled population and only 17 percent by the increase in reimbursements per enrollee. (The parceling method is described in Klarman et al., 1970.)

Medicaid services

Trends in Medicaid payments for skilled nursing and intermediate care facilities are shown in Figure 2.11. Data on Medicaid payments for hospital outpatient services, home health services, and drug prescriptions are shown in Figure 2.12. Detailed information on changes in these services is presented in Tables 2.16–2.20.

Figure 2.11
Medicaid payments for nursing facility services, by type of service: Fiscal years 1975-85

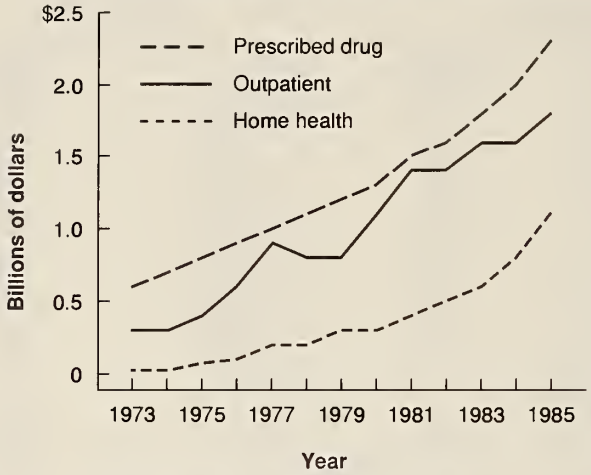


[1] Excludes intermediate care facilities for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 2.12

Medicaid payments for selected services: Fiscal years 1973-85



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Skilled nursing facilities and intermediate care facilities

Data on use of and payments to skilled nursing facilities under Medicaid are shown in Table 2.16. From 1973 to 1985, recipients in skilled nursing facilities and total days of care declined at annual rates of 1.8 and 1.5 percent, respectively. Both declined from 1973 to 1975 but have fluctuated since then. In spite of these fluctuations in use, payments grew steadily at an annual rate of 8.3 percent.

Data on trends in the use of and payments to intermediate care facilities during the period 1975–85 are presented in Table 2.17. Payments grew at an annual rate of 13.2 percent. The numbers of recipients and days of care grew more slowly, 2.0 and 2.2 percent per year, respectively.

Hospital outpatient services

Data on Medicaid utilization of hospital outpatient services during the period 1973–85 are reported in Table 2.18. The number of recipients grew 5.5 percent annually from 1973 through 1985, and payments increased more than three times as fast as number of recipients.

Home health services

As shown in Table 2.19, home health care is one of the fastest growing services covered by Medicaid. From 1973 through 1985, the number of recipients increased at an average annual rate of 14.1 percent. Payments grew at an even higher rate, 37.1 percent per year.

Table 2.16

Medicaid recipients, days of care, and payments for skilled nursing facility services: Fiscal years 1973–85

Year	Recipients	Days of care	Payments in millions
	Number in thousands		
1973[1]	678	133,905.0	$1,958.9
1974[2]	661	130,547.5	2,001.9
1975	630	120,672.5	2,434.2
1976	637	122,252.5	2,475.6
1977	641	124,622.5	2,691.2
1978	639	125,412.5	3,125.0
1979	610	117,117.5	3,379.5
1980	609	120,277.5	3,685.2
1981	623	125,412.5	4,035.4
1982	559	110,205.0	4,426.7
1983	574	123,114.5	4,621.0
1984	559	111,383.9	4,810.3
1985	547	111,670.8	5,072.5
		Percent	
ACRG[3]	−1.8	−1.5	8.3

[1] Includes intermediate care facilities in Michigan.
[2] Includes intermediate care facilities in West Virginia, Missouri, and North Carolina.
[3] Annual compound rate of growth.

NOTE: Estimates were made for States with missing data. Therefore, figures may differ from those in Table 4.12.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.17

Medicaid recipients, days of care, and payments for intermediate care facility services: Fiscal years 1975–85

Year	Recipients	Days of care	Payments in millions
	Number in thousands		
1975	682	167,184.8	$1,885.0
1976	724	178,812.8	2,208.5
1977	754	193,283.2	2,637.2
1978	740	190,957.6	3,104.4
1979	766	194,316.8	3,773.2
1980	789	203,877.6	4,201.7
1981	762	199,484.8	4,506.7
1982	765	197,934.4	4,979.0
1983	793	201,199.3	5,380.6
1984	796	202,133.6	5,822.5
1985	829	207,098.1	6,525.8
		Percent	
ACRG[1]	2.0	2.2	13.2

[1] Annual compound rate of growth.

NOTES: Data exclude intermediate care facilities for the mentally retarded. Data for 1973 and 1974 are not available.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Prescription drugs

Data on use of and payments for prescription drugs under Medicaid[5] are shown in Table 2.20. Both the number of recipients and number of prescriptions grew

[5] Medicare does not cover the cost of drugs outside an inpatient setting.

Table 2.18

Medicaid recipients and payments for hospital outpatient services: Fiscal years 1973–85

Year	Recipients in thousands	Payments in millions
1973	5,295.4	$267.6
1974	5,544.5	322.0
1975	7,436.8	372.8
1976	8,482.2	555.3
1977	8,618.9	876.6
1978	8,628.0	834.6
1979	7,710.4	847.4
1980	9,704.9	1,101.1
1981	10,017.9	1,409.1
1982	9,852.5	1,437.7
1983	10,068.6	1,574.2
1984	10,034.5	1,646.3
1985	10,072.5	1,789.1
	Percent	
ACRG[1]	5.5	17.2

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.19

Medicaid recipients and payments for home health services: Fiscal years 1973–85

Year	Recipients in thousands	Payments in millions
1973	109.9	$25.4
1974	134.7	31.1
1975	342.8	70.0
1976	319.2	134.1
1977	370.8	180.0
1978	376.5	210.0
1979	358.9	263.5
1980	392.4	332.0
1981	401.7	427.8
1982	377.3	495.5
1983	421.8	597.2
1984	437.7	773.6
1985	535.3	1,119.7
	Percent	
ACRG[1]	14.1	37.1

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 2.20

Selected measures of use of prescription drugs under Medicaid: Fiscal years 1973–85

Year	Recipients	Prescriptions	Number of prescriptions per recipient	Payments in millions
	Number in thousands			
1973	12,116.2	127,293.4	10.5	$609.3
1974	14,240.0	143,179.5	10.1	712.6
1975	14,155.4	154,701.1	10.9	814.9
1976	14,883.3	170,287.8	11.4	939.6
1977	15,369.9	173,891.1	11.3	1,018.2
1978	15,187.8	176,991.2	11.7	1,081.7
1979	14,282.9	177,657.2	12.4	1,196.3
1980	13,707.4	169,457.2	12.4	1,318.3
1981	14,255.7	176,215.0	12.4	1,534.7
1982	13,546.7	175,830.8	13.0	1,598.9
1983	13,731.8	177,436.8	12.9	1,771.2
1984	13,934.6	181,060.8	13.0	1,968.2
1985	13,920.6	190,126.5	13.7	2,315.5
		Percent		
ACRG[1]	1.2	3.4	2.2	11.8

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

over the period, with the growth in the number of prescriptions outpacing that of recipients. The number of prescriptions per recipient grew at a rate of 2.2 percent per year, increasing from 10.5 per recipient in 1973 to 13.7 per recipient in 1985. Payments for prescriptions grew steadily at an annual rate of 11.8 percent.

Medicare cost sharing

Estimates of Medicare cost sharing (coinsurance and deductible) by HI and SMI enrollees are shown in Table 2.21. These cost-sharing amounts do not include amounts due to physicians on unassigned claims that exceed the charges allowed by Medicare. Aged and disabled Medicare enrollees who used the HI program (hospitals and SNF's) incurred $3.4 billion in cost-sharing expenses in 1984. In 1984, the HI deductible accounted for 82 percent of HI enrollee liabilities for the aged and the disabled combined.

The disabled, excluding persons entitled to Medicare solely because of ESRD, had HI liabilities per enrollee that were somewhat higher than those of the aged in each year beginning with 1977. As can be derived from Table 2.21, from 1977 to 1984, HI liabilities of aged and disabled enrollees rose at an average annual rate of nearly 18 percent. The increase was primarily caused by rising hospital charges, as reflected in the increase in the deductible from $124 per benefit period in 1977 to $356 in 1984 and the accompanying increase in the coinsurance amount. However, from 1983 to 1984, the coinsurance

amount of the aged and disabled decreased 15 percent. The prospective payment system resulted in a decrease in the average length of hospital stay and, in turn, a decrease in the number of coinsurance days and the amount of coinsurance liability (Ruther, 1987).

Total liabilities for SMI services in 1984 are estimated at $6.1 billion. Because the SMI deductible is a fixed annual amount, $60 for the years 1973–81 and $75 since 1982, deductibles accounted for only 25 percent of total liabilities for all enrollees in 1984. As derived from Table 2.21, SMI liabilities increased at an average annual rate of nearly 14 percent from 1977 to 1984.

Personal health care expenditures

Estimates of personal health care expenditures in the United States for the direct provision of medical care goods and services for selected calendar years 1965–85 are shown in Table 2.22. The data are estimates made by HCFA's Division of National Cost Estimates (Waldo, Levit, and Lazenby, 1986). Personal health care expenditures in 1985 comprised direct patient payments, $105.6 billion, and indirect, or third-party, payments, $265.8 billion. Third-party payments consisted of private health insurance and other private funds, $118.4 billion, and public funds, $147.5 billion. Public funds consisted of $112.6 billion in Federal funds and $34.8 billion in State and local funds. Medicare funds, $70.5 billion, and Medicaid funds, $39.8 billion, are shown separately in the table. Medicaid comprises $21.9 billion in Federal funds and $17.9 billion in State and local funds (not shown in Table 2.22).

In 1965, before the Medicare and Medicaid programs began, direct patient payments were $91 per capita and accounted for 51.6 percent of total personal health care payments. Private health insurance paid 24.2 percent of personal health care expenditures, the Federal Government paid 10.1 percent, and State and local governments paid 11.9 percent. By 1985, direct patient payments had risen to $428 per capita but had decreased to 28.4 percent of personal health care expenditures. Private health insurance payments rose from $42 to $460 per capita in the 1965–85 period and increased from 24.2 to 30.6 percent of expenditures. The rise in the proportion of private health insurance payments resulted from persons seeking to reduce the risk of high out-of-pocket payments. Reflecting rising Medicare and Medicaid payments, the Federal share of personal health care expenditures jumped from $18 to $456 per capita in the same period and rose from 10.1 to 30.3 percent of expenditures. State and local expenditures were a decreasing share of payments, falling from 11.9 percent in 1965 to 9.4 percent in 1985. Medicare payments rose from 10.9 percent of total payments in 1970 to 19.0

Table 2.21

Hospital insurance and supplementary medical insurance cost-sharing deductible and coinsurance amounts for Medicare aged and disabled enrollees: United States, calendar years 1977–84

Type of coverage and year	Cost sharing											
	Total		Deductible		Coinsurance[1]		Total		Deductible		Coinsurance[1]	
	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
Hospital insurance	Amount in millions						Amount per enrollee[2]					
1977	$972	$119	$756	$88	$216	$31	$42	$46	$33	$34	$9	$12
1978	1,161	150	907	112	254	38	49	54	38	40	11	14
1979	1,333	179	1,035	133	298	46	55	62	43	46	12	16
1980	1,595	212	1,239	156	356	56	65	72	50	53	14	19
1981	1,836	244	1,434	181	402	63	73	82	57	61	16	21
1982	2,588	325	2,037	240	551	85	101	110	79	81	21	29
1983	2,886	364	2,237	273	649	91	108	125	84	94	24	31
1984	3,032	370	2,482	293	550	77	112	128	91	102	20	27
					Percent							
ACRG[3]	17.6	17.6	18.5	18.7	14.3	13.9	15.0	15.7	15.6	17.0	12.1	12.3
Supplementary medical insurance	Amount in millions						Amount per enrollee[2]					
1977	$2,210	$305	$966	$81	$1,244	$224	$96	$129	$42	$34	$54	$95
1978	2,469	369	1,009	90	1,460	279	105	146	43	36	62	110
1979	2,801	445	1,059	99	1,742	346	117	168	44	37	73	131
1980	3,213	528	1,102	105	2,111	423	131	195	45	39	86	156
1981	3,721	617	1,154	108	2,567	509	148	225	46	39	102	186
1982	4,691	747	1,507	141	3,184	606	183	275	59	52	124	223
1983	5,131	748	1,475	141	3,656	607	195	279	56	53	139	226
1984	5,368	771	1,396	136	3,972	635	201	291	52	51	148	240
					Percent							
ACRG[3]	13.5	14.2	5.4	7.7	18.0	16.1	11.1	12.3	3.1	6.0	15.5	14.2

[1] Includes coinsurance payments for both hospitals and skilled nursing facilities.
[2] Based on average annual enrollment.
[3] Annual compound rate of growth.

NOTES: Excludes cost-sharing payments of end stage renal disease patients. Data may be revised.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Office of Research.

Table 2.22

Personal health care expenditures—amount, per capita, and percent distribution, by source of funds: Selected calendar years 1965–85

Year	Total	Direct patient payments	Third parties							
			All third parties	Private health insurance	Other private funds	Government				
						Total	Federal	State and local	Medicare[1]	Medicaid[2]
					Amount in billions					
1965	$35.9	$18.5	$17.3	$8.7	$0.8	$7.9	$3.6	$4.3	—	—
1970	65.4	26.5	38.9	15.3	1.1	22.4	14.5	7.9	$7.1	$5.2
1975	117.1	38.1	79.0	31.2	1.6	46.3	31.4	14.9	15.6	13.5
1980	219.7	63.0	156.7	67.5	2.7	86.5	62.5	24.0	35.7	25.2
1984	341.1	97.8	243.3	104.9	4.3	134.1	100.9	33.2	62.9	36.3
1985	371.4	105.6	265.8	113.5	4.9	147.5	112.6	34.8	70.5	39.8
					Per capita amount					
1965	$176	$91	$85	$42	$4	$39	$18	$21	NA	NA
1970	304	123	181	71	5	104	68	37	NA	NA
1975	521	169	351	139	7	206	140	66	NA	NA
1980	934	268	666	287	11	367	266	102	NA	NA
1984	1,394	400	994	429	18	548	412	136	NA	NA
1985	1,504	428	1,076	460	20	597	456	141	NA	NA
					Percent distribution					
1965	100.0	51.6	48.4	24.2	2.2	22.0	10.1	11.9	—	—
1970	100.0	40.5	59.5	23.4	1.7	34.3	22.2	12.1	10.9	8.0
1975	100.0	32.5	67.5	26.7	1.3	39.5	26.8	12.7	13.3	11.6
1980	100.0	28.7	71.3	30.7	1.2	39.4	28.4	10.9	16.2	11.5
1984	100.0	28.7	71.3	30.7	1.3	39.3	29.6	9.7	18.4	10.7
1985	100.0	28.4	71.6	30.6	1.3	39.7	30.3	9.4	19.0	10.7

[1] Subset of Federal funds.
[2] Subset of Federal and State and local funds.

NOTE: Per capita amounts are based on July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

percent in 1985. In the same period, Medicaid payments increased at a slower rate, from 8.0 percent of total payments to 10.7. As derived from the table, the Medicare and Medicaid programs combined accounted for about three-quarters of all public spending for personal health care in 1985. Medicare accounted for 47.8 percent of all public payments, Medicaid accounted for 27.0 percent of all public payments, and the remaining payments, 25.2 percent, were mainly from the Veterans' Administration and the Department of Defense.

3. Medicare: Description and data

In this chapter, detailed information on the Medicare program is presented. This program for financing health care for the aged was enacted on July 30, 1965, as title XVIII of the Social Security Act. Benefits began on July 1, 1966. The Medicare program (Health Insurance for the Aged) was substantially expanded by the 1972 Amendments to the Social Security Act (Public Law 92–603). These amendments (effective July 1, 1973) extended Medicare coverage to disabled beneficiaries of the social security and railroad retirement programs and to persons requiring dialysis or a kidney transplant for end stage renal disease. The official name of the Medicare program was then changed to Health Insurance for the Aged and Disabled. Major changes in the Medicare law through the Omnibus Budget Reconciliation Act (OBRA) of 1985 (Public Law 99–272), which became law on April 7, 1986, are described in this report.

The Secretary of the Department of Health and Human Services (DHHS) has overall responsibility for the Medicare program. Within DHHS, the Health Care Financing Administration (HCFA) administers Medicare. Medicare consists of two separate but complementary insurance programs: hospital insurance (HI) and supplementary medical insurance (SMI). HI covers inpatient hospital and skilled nursing facility services, and SMI covers physicians' and related services for eligible persons who voluntarily pay premiums or whose premiums are paid for them.

In the next four sections, eligibility standards, benefits, financing, and administration are described for both HI and SMI. Analysis of the distribution of benefits is presented according to the following formula:

$$\frac{\text{Persons served}}{\text{Enrollees}} \times \frac{\text{Reimbursements}}{\text{Persons served}} = \frac{\text{Reimbursements}}{\text{Enrollees}}$$

where

Persons served are persons who exceeded deductibles (HI or SMI) and were reimbursed by Medicare for services received;

Persons served/enrollees is the proportion of enrollees who exceeded deductibles and were reimbursed for covered services;

Reimbursements/persons served is the average Medicare reimbursement for persons who received Medicare reimbursements; and

Reimbursements/enrollees is the average Medicare reimbursement for a population group.

In the final sections of this chapter, the Medicare program's arrangements with risk group health plans are discussed and the Medicare statistical system is described.

Eligibility

All persons 65 years of age or over who are entitled to monthly social security cash benefits or payments from the railroad retirement system are eligible for benefits under the HI program. Since July 1, 1973, disabled persons entitled to cash benefits under the social security or railroad retirement programs have also been eligible for HI benefits. A person must be disabled for 5 calendar months before disability benefits begin and then be entitled to 24 months of cash benefits before becoming eligible for HI benefits. Thus, Medicare coverage begins the 30th month after the first full calendar month of disability.

HI protection also extends to persons who have end stage renal disease (ESRD) and require renal dialysis or a kidney transplant if they are currently insured, entitled to monthly social security benefits, or are the spouses or dependent children of such insured persons. Eligibility for coverage begins the third month after renal dialysis treatments begin or before this qualifying dialysis period for ESRD enrollees who receive kidney transplants without starting or receiving dialysis in preparation for transplantation. Eligibility ends with the 36th month after a person receives a kidney transplant or after dialysis treatment has been terminated.

The 1972 Amendments to the Social Security Act, effective July 1973, permit most persons 65 years of age or over who are ineligible for HI coverage to enroll voluntarily by paying a monthly premium. This "premium-HI" was set at $226 a month for 1987 and represents the full premium cost of HI. To obtain premium-HI, the enrollee must also obtain SMI coverage.

Persons entitled to benefits under the HI program and most other persons 65 years of age or over may voluntarily enroll in SMI. Only the aged can enroll in SMI without being eligible for HI; disabled persons may not. The Omnibus Budget Reconciliation Act of 1981, effective October 1, 1981, instituted a general enrollment period, which occurs from January through March of each year. Coverage becomes effective July 1. Persons may terminate SMI enrollment by not paying premiums. A person may reenroll by paying a surcharge of 10 percent for every 12 months that he or she could have been enrolled. Coverage will begin again on July 1. Under the State buy-in system, a State government may enroll and pay SMI premiums for eligible aged and disabled individuals who are also covered by the Medicaid program.

Data on the total number of aged and disabled persons enrolled in Medicare (HI and/or SMI) in 1983 and 1984 are shown in Table 3.1. Total Medicare enrollees, 91 percent of whom were aged, numbered 30.5 million in 1984. Ninety-eight percent of the aged were enrolled in both HI and SMI or only in HI. The remainder, 459,400 aged who were ineligible for HI, were enrolled only in SMI. Ninety-two percent of disabled HI enrollees were also enrolled in SMI.

In Table 3.2, the number of aged and disabled enrollees in 1984 for both HI and SMI is shown by census region and division. For both aged and disabled groups, the greatest number of enrollees resided in the South, and the smallest number resided in the West.

Table 3.1

Number of aged and disabled Medicare enrollees, by type of coverage: July 1, 1983 and 1984

Type of enrollee	Hospital insurance and/or supplementary medical insurance		Hospital insurance		Supplementary medical insurance	
	1983	1984	1983	1984	1983	1984
	Number in thousands					
Total	30,026.1	30,455.4	29,587.3	29,996.0	28,974.5	29,415.4
Aged[1]	27,108.5	27,571.0	26,669.7	27,111.6	26,292.1	26,764.2
Disabled[2]	2,917.6	2,884.4	2,917.6	2,884.4	2,682.4	2,651.2

[1] All enrollees 65 years of age or over, including enrollees with end stage renal disease (ESRD).
[2] All enrollees under 65 years of age, including enrollees with ESRD.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.2

Number of Medicare enrollees, by type of coverage, type of enrollee, census region, and census division: July 1, 1984

Census region and division	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Total	Aged	Disabled[1]	Total	Aged	Disabled[1]	Total	Aged	Disabled[1]
All areas	30,455,368	27,570,950	2,884,418	29,995,971	27,111,561	2,884,410	29,415,397	26,764,150	2,651,247
United States[2]	29,824,396	27,045,092	2,779,304	29,366,334	26,587,038	2,779,296	29,119,553	26,518,889	2,600,664
Northeast	6,937,759	6,334,234	603,525	6,844,060	6,240,537	603,523	6,784,751	6,223,137	561,614
New England	1,744,657	1,606,841	137,816	1,724,656	1,586,840	137,816	1,703,036	1,576,642	126,394
Middle Atlantic	5,193,102	4,727,393	465,709	5,119,404	4,653,697	465,707	5,081,715	4,646,495	435,220
North Central	7,716,088	7,055,862	660,226	7,639,347	6,979,122	660,225	7,558,774	6,944,487	614,287
East North Central	5,254,200	4,772,366	481,834	5,196,402	4,714,569	481,833	5,145,195	4,697,103	448,092
West North Central	2,461,888	2,283,496	178,392	2,442,945	2,264,553	178,392	2,413,579	2,247,384	166,195
South	9,982,610	8,930,070	1,052,540	9,788,446	8,735,909	1,052,537	9,724,848	8,734,670	990,178
South Atlantic	5,215,100	4,675,470	539,630	5,115,526	4,575,897	539,629	5,088,752	4,580,693	508,059
East South Central	1,965,583	1,718,018	247,565	1,921,383	1,673,819	247,564	1,917,038	1,682,369	234,669
West South Central	2,801,927	2,536,582	265,345	2,751,537	2,486,193	265,344	2,719,058	2,471,608	247,450
West	5,166,080	4,705,817	460,263	5,074,143	4,613,882	460,261	5,032,639	4,600,543	432,096
Mountain	1,317,107	1,204,789	112,318	1,302,124	1,189,806	112,318	1,277,494	1,173,806	103,688
Pacific	3,848,973	3,501,028	347,945	3,772,019	3,424,076	347,943	3,755,145	3,426,739	328,408

[1] Includes disabled enrollees under age 65 with end stage renal disease and enrollees with end stage renal disease only.
[2] Includes 50 States, District of Columbia, and unknown residence.

NOTE: This table is based on data recorded in the Medicare health insurance master file on March 31, 1985.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Detailed information on the distribution of HI and SMI benefits for aged and disabled enrollees is presented in Tables 3.3 and 3.4. Much larger proportions of aged and disabled enrollees received SMI benefits than HI benefits (persons served per 1,000 enrollees). For both groups, average reimbursements per person served were far higher for HI than for SMI. The proportions of both aged and disabled enrollees receiving benefits were higher for older age groups for both HI and SMI.

Benefits

Overview

The HI program covers inpatient hospital care and posthospital care in skilled nursing facilities (SNF's). The program also covers home health agency services for persons confined to the home who need skilled nursing care or physical or speech therapy. To be covered, services must be provided by institutions and organizations that have been certified as qualified providers and have agreements to participate in the program. Exceptions to this rule are made for emergency services.

Prior to the Omnibus Budget Reconciliation Act of 1980, the HI program covered home health visits only if they followed a hospital stay. Home health visits that did not follow a hospital stay were covered by the SMI program. Coverage was limited to 100 visits per benefit period for HI and 100 visits in a calendar year for SMI. OBRA of 1980, effective July 1, 1981, eliminated the HI requirement for prior hospitalization and the limits on visits. Under the new law, all home health visits are covered by the HI program unless a beneficiary has SMI coverage only. In such cases, home health visits are covered by the SMI program.

The SMI program covers a variety of medical services and supplies furnished by physicians or other health care professionals in connection with physicians' services. It also covers outpatient and home health services.

Table 3.3

Persons served and reimbursements for aged Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1984

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	685.7	$2,756	$1,890	239.6	$5,553	$1,331	698.9	$857	$599
Age									
65–69 years	619.0	2,292	1,419	174.7	5,475	956	633.1	773	490
70–74 years	670.0	2,662	1,784	217.2	5,659	1,229	679.7	869	591
75–79 years	721.0	2,940	2,120	265.8	5,646	1,501	730.8	920	672
80–84 years	758.8	3,171	2,406	316.6	5,507	1,744	769.9	916	705
85 years or over	780.6	3,316	2,589	358.4	5,422	1,943	811.8	859	697
Sex									
Male	650.9	3,116	2,028	246.9	5,809	1,435	665.8	952	634
Female	708.9	2,536	1,798	234.7	5,371	1,261	720.8	799	576
Race[1]									
White	691.8	2,731	1,890	241.3	5,487	1,324	703.1	850	598
Other	635.8	3,055	1,942	227.6	6,276	1,428	663.2	935	620
Census region									
Northeast	728.7	2,829	2,062	236.3	6,209	1,467	735.5	854	628
North Central	682.3	2,786	1,901	248.5	5,533	1,375	687.5	804	552
South	676.1	2,620	1,771	258.0	4,867	1,256	683.7	812	555
West	704.6	2,909	2,050	212.8	6,345	1,350	711.3	1,033	735

[1] Excludes unknown race.

NOTE: Inpatient hospital reimbursement includes prospective payment system short-stay hospital inpatient passthrough expenditures reported on the Health Care Financing Administration intermediary benefit payment report.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Counts of the number of institutional providers participating in Medicare from 1976 through 1984 are presented in Table 3.5. The number of home health agencies (HHA's) doubled in size in this period. This was partly the result of OBRA of 1980, which permitted HHA's to operate in States not having licensure laws and removed certain restrictions on HHA benefits. Most of the Nation's hospitals participated in Medicare, and they constituted the largest category of participating providers (6,675 hospitals in 1984). Hospitals also received the largest share of Medicare reimbursements. As shown in Table 3.6, almost all HI benefit payments in 1985 and 63 percent of total Medicare payments went for hospital inpatient services. SMI benefit payments accounted for 33 percent of total payments; 75 percent of SMI payments were for physicians' services. The distribution of payments differed for aged and disabled enrollees. Disabled enrollees received a smaller proportion of HI payments and a larger proportion of SMI payments than aged enrollees.

Information on the distribution of specific benefits for aged and disabled enrollees is presented in Tables 3.7 and 3.8. In 1984, the proportion of aged enrollees receiving all listed benefits was successively higher for each age group. Among the aged, the largest proportion by far received physicians' services, followed by outpatient and inpatient hospital services. Only small proportions of aged enrollees received SNF or home health benefits.

With the exception of inpatient hospital benefits, a larger proportion of aged women than men received benefits. Larger proportions of white enrollees received reimbursements for all services except outpatient and home health services, for which the proportions were greater for enrollees of all other races. Aged enrollees of all other races had higher reimbursements per person served than aged white enrollees for all services. For all aged enrollees, reimbursement per person served was highest for inpatient hospital services ($5,502), followed by skilled nursing facility services ($1,580) and home health agency services ($1,096). Reimbursements per person served for physicians' and outpatient services were $729 and $319, respectively.

For each service, the amount reimbursed per person served was higher for the disabled than for the aged. The amount of outpatient reimbursement per disabled person served was much higher than the amount for the aged because of the higher proportion of ESRD patients among the disabled.

Table 3.4

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1984

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	639.5	$3,807	$2,435	242.6	$6,477	$1,571	683.5	$1,374	$939
Age									
Under 35 years	565.3	4,122	2,330	191.3	7,388	1,414	601.5	1,638	985
35–44 years	573.7	3,897	2,236	201.6	6,788	1,369	622.5	1,529	952
45–54 years	624.9	3,928	2,455	242.5	6,409	1,554	676.6	1,465	991
55–59 years	657.4	3,840	2,525	259.8	6,420	1,668	703.2	1,332	936
60–64 years	699.7	3,574	2,501	272.7	6,170	1,682	737.7	1,198	884
Sex									
Male	586.7	3,783	2,219	224.8	6,499	1,461	632.1	1,324	837
Female	731.3	3,841	2,809	273.6	6,445	1,763	770.2	1,444	1,112
Race[1]									
White	640.1	3,631	2,324	242.5	6,298	1,527	685.4	1,270	870
Other	638.2	4,624	2,951	244.1	7,302	1,782	678.0	1,851	1,255
Census region									
Northeast	691.2	3,850	2,661	237.9	7,173	1,706	731.1	1,403	1,026
North Central	653.2	3,921	2,561	252.5	6,841	1,727	690.6	1,308	903
South	624.0	3,624	2,261	265.2	5,577	1,478	650.7	1,281	833
West	685.8	4,129	2,832	221.9	7,690	1,707	721.0	1,650	1,190

[1] Excludes unknown race.

NOTE: Inpatient hospital reimbursement includes prospective payment system short-stay hospital inpatient passthrough expenditures reported on the Health Care Financing Administration intermediary benefit payment report.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.5

Number of facilities participating in Medicare, by type of facility: July 1, 1976–84

Type of facility	1976	1977	1978	1979	1980	1981	1982	1983	1984	Percent change 1976–84
						Number				
Hospitals	6,802	6,806	6,797	6,801	6,777	6,736	6,742	6,687	6,675	–1.3
Short-stay	6,112	6,131	6,130	6,128	6,104	6,065	6,070	6,048	6,038	–1.2
Long-stay:										
Psychiatric	401	400	400	411	408	412	419	430	433	8.0
Other long-stay	289	275	267	262	265	259	253	209	204	–29.4
Skilled nursing facilities	3,928	4,002	4,749	4,963	5,052	5,258	5,408	5,760	5,952	51.5
Home health agencies	2,361	2,420	2,605	2,788	2,924	3,110	3,415	4,235	4,684	98.4
Independent laboratories	3,194	3,221	3,281	3,373	3,447	3,484	3,581	3,708	3,801	19.0

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.6

Medicare benefit payments, by type of enrollee, type of coverage, and type of service: Calendar year 1985

Type of coverage and type of service	All enrollees		Aged		Disabled	
	Amount in millions	Percent distribution	Amount in millions	Percent distribution	Amount in millions	Percent distribution
Total	$70,527	100.0	$62,305	100.0	$8,222	100.0
Hospital insurance	47,580	67.5	42,194	67.7	5,386	65.5
Inpatient[1]	44,653	63.3	39,456	63.3	5,197	63.2
Skilled nursing facility[2]	623	0.9	603	1.0	20	0.2
Home health agency	2,304	3.3	2,135	3.4	169	2.1
Supplementary medical insurance	22,947	32.5	20,111	32.3	2,836	34.5
Physicians'	17,312	24.5	15,558	25.0	1,754	21.3
Outpatient	4,311	6.1	3,357	5.4	954	11.6
Home health agency	45	0.1	44	0.1	1	0.0
Group practice plan	720	1.0	647	1.0	73	0.9
Independent laboratory[3]	559	0.8	505	0.8	54	0.7

[1] Includes $136 million for peer review organizations, counted as an inpatient hospital benefit in other actuarial tables.
[2] Includes hospices.
[3] Includes only services billed directly by providers.

NOTE: Total, hospital insurance, and supplementary medical insurance benefit payments are actual amounts reported in Medicare trust fund reports. Distributions by provider are preliminary estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare Cost Estimates.

Table 3.7

Persons served and reimbursements for aged Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1984

Characteristic	Hospital insurance						Supplementary medical insurance—physicians' and other medical services		
	Inpatient hospital services[1]			Skilled nursing facility services					
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	228.5	$5,502	$1,257	10.7	$1,580	$17	677.3	$729	$494
Age									
65–69 years	170.0	5,454	927	2.8	1,798	5	607.6	650	395
70–74 years	209.7	5,611	1,177	6.2	1,586	10	659.1	733	483
75–79 years	253.5	5,577	1,414	11.5	1,620	19	711.1	781	555
80–84 years	297.5	5,435	1,617	19.8	1,557	31	751.2	791	594
85 years or over	329.4	5,369	1,769	34.3	1,510	52	792.7	753	597
Sex									
Male	238.1	5,774	1,375	8.3	1,513	13	643.7	815	524
Female	222.0	5,301	1,178	12.3	1,610	20	699.5	677	474
Race[2]									
White	230.6	5,436	1,253	11.1	1,566	17	682.8	728	497
Other	212.7	6,243	1,328	7.4	1,796	13	628.0	741	465
Census region									
Northeast	223.5	6,194	1,385	9.8	1,799	18	699.1	731	511
North Central	238.5	5,509	1,314	13.0	1,508	20	667.2	673	449
South	246.9	4,781	1,180	8.1	1,429	12	667.0	699	467
West	203.0	6,258	1,271	14.5	1,637	24	698.4	870	607

See footnotes at end of table.

Table 3.7—Continued

Persons served and reimbursements for aged Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1984

Characteristic	Supplementary medical insurance—outpatient services			Hospital insurance and/or supplementary medical insurance—home health agency services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee
Total	326.7	$319	$104	51.6	$1,096	$57
Age						
65–69 years	293.1	322	95	24.2	1,081	26
70–74 years	319.4	334	107	40.2	1,093	44
75–79 years	344.3	335	115	62.0	1,096	68
80–84 years	358.0	308	110	86.3	1,087	94
85 years or over	380.8	263	100	105.6	1,118	118
Sex						
Male	314.0	346	109	45.0	1,083	49
Female	335.1	302	101	56.0	1,103	62
Race[2]						
White	326.2	306	100	50.6	1,067	54
Other	336.7	449	151	64.9	1,309	85
Census region						
Northeast	381.9	306	117	62.7	1,034	65
North Central	342.8	300	103	45.6	939	43
South	284.2	306	87	51.4	1,236	64
West	317.5	399	127	47.6	1,170	56

[1] Includes prospective payment system short-stay hospital inpatient passthrough expenditures reported on the Health Care Financing Administration intermediary benefit payment report.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.8

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1984

Characteristic	Hospital insurance						Supplementary medical insurance—physicians' and other medical services		
	Inpatient hospital services[1]			Skilled nursing facility services					
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	233.7	$6,512	$1,522	3.1	$1,675	$5	649.3	$900	$584
Age									
Under 35 years	186.4	7,456	1,390	1.2	1,717	2	553.4	874	484
35–44 years	194.7	6,841	1,332	1.5	1,559	2	582.6	873	508
45–54 years	234.2	6,440	1,508	2.6	1,753	5	643.0	917	590
55–59 years	250.5	6,439	1,613	3.6	1,622	6	673.6	927	625
60–64 years	261.1	6,197	1,618	4.6	1,687	8	708.5	892	632
Sex									
Male	217.2	6,553	1,423	2.5	1,707	4	596.7	884	528
Female	262.5	6,452	1,694	4.1	1,642	7	738.0	921	679
Race[2]									
White	233.8	6,327	1,480	3.2	1,665	5	654.4	886	580
Other	234.1	7,371	1,726	2.6	1,752	5	628.7	964	606
Census region									
Northeast	227.6	7,231	1,646	2.5	1,977	5	676.1	891	602
North Central	243.8	6,914	1,686	4.3	1,588	7	659.1	874	576
South	256.5	5,573	1,429	2.3	1,479	3	621.5	839	521
West	214.3	7,707	1,652	4.6	1,822	8	698.1	1,096	765

See footnotes at end of table.

Table 3.8—Continued

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1984

Characteristic	Supplementary medical insurance—outpatient services			Hospital insurance and/or supplementary medical insurance—home health agency services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee
Total	387.9	$915	$355	34.6	$1,265	$44
Age						
Under 35 years	384.9	1,303	501	16.2	1,496	24
35–44 years	382.7	1,158	443	23.4	1,478	35
45–54 years	394.9	1,016	401	31.0	1,303	40
55–59 years	390.6	798	312	39.1	1,236	48
60–64 years	385.6	653	252	47.2	1,180	56
Sex						
Male	350.9	881	309	28.0	1,204	34
Female	450.4	961	433	46.0	1,328	61
Race[2]						
White	379.9	765	291	33.4	1,260	42
Other	428.8	1,513	649	40.4	1,285	52
Census region						
Northeast	457.5	926	423	43.2	1,255	54
North Central	402.0	815	328	32.3	1,091	35
South	344.4	906	312	33.2	1,365	45
West	401.5	1,058	425	33.5	1,346	45

[1] Includes prospective payment system short-stay hospital inpatient passthrough expenditures reported on the Health Care Financing Administration intermediary benefit payment report.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Hospital insurance

The law governing the HI program limits coverage to a benefit period (or "spell of illness"). A benefit period begins with an enrollee's first day of hospitalization and ends when the enrollee has not been an inpatient in a hospital or skilled nursing facility for at least 60 consecutive days. Although there is no limit to the number of benefit periods that an enrollee may have, there are limits on the number of days covered.

HI covers up to 90 days of services in a participating hospital during a single benefit period. After an initial deductible for each benefit period, the patient is entitled to 60 days of hospitalization with no additional cost sharing. From the 61st through the 90th day in the benefit period, the patient is responsible for coinsurance ($130 per day in 1987) equal to one-fourth of the deductible. The Secretary of DHHS is required each year to determine the deductible amount using a formula specified by law. Reflecting increases in hospital costs, the deductible has risen from $40 in 1966 to $520 in 1987.

HI enrollees also have a "lifetime reserve" of 60 additional hospital days, which can be used at their option when the 90 days covered in a benefit period have been exhausted. Lifetime reserve days require a coinsurance equal to one-half the deductible ($260 for each lifetime reserve day in 1987).

In addition, the HI program pays nonparticipating hospitals for emergency services. The hospital may bill the program annually for all emergency services rendered. If this arrangement is unacceptable to the provider, the patient must pay for services received and submit a claim for reimbursement. Reimbursements are subject to a deductible and coinsurance.

Hospital services covered under HI include room and board in "semiprivate" accommodations containing from two to four beds. Private accommodations are covered if medically necessary; otherwise, the patient must pay a special charge to the hospital. Nursing services (except private-duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients are also covered. The HI program covers the services of interns and resident physicians in approved teaching programs. Services of other physicians, including hospital-based specialists such as radiologists, anesthesiologists, and pathologists, are covered under SMI. Hospital benefits also include reimbursement for inpatient services provided by tuberculosis hospitals and psychiatric hospitals. There is a 190-day lifetime limit for psychiatric hospitals.

Prior to the 1983 Amendments to the Social Security Act (Public Law 98-21), effective October 1, 1983, the HI program paid hospitals the "reasonable costs" of providing services to Medicare beneficiaries. Reasonable costs were determined after services had been delivered

and were based on program regulations. The Medicare law and regulations specified the kinds of hospital costs allowed. Medicare, for example, does not cover private-duty nursing or costs unrelated to patient care. Once a hospital's total allowable costs were determined, Medicare apportioned the cost between Medicare patients and other patients. Medicare then paid allowable costs based on services received by Medicare patients.

The 1983 Amendments to the Social Security Act established prospective payments for Medicare inpatient hospital services, which changed the way hospitals are paid. This legislation reformed the retrospective cost-based reimbursement system for inpatient care, through which payments were made for reasonable costs incurred during the preceding year. The new prospective payment system established one price for each diagnosis-related group (DRG). Based on diagnosis and other characteristics, the DRG system classifies patients into clinically coherent and homogeneous groups that use similar resources. Prices are established in advance for the coming year, and hospitals are paid these prices regardless of the costs they actually incur. Hospitals earn a profit when their costs fall below the prospective payment or absorb a loss when their costs are above the prospective payment. It is hoped that the prospective payment system will provide incentives for hospitals to control costs. The prospective payment system was to be phased in over a 3-year period beginning October 1983. OBRA of 1985 extended the phase-in period an additional year.

Hospice use

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 provided a new HI benefit, hospice care for the terminally ill. A hospice is a public agency or private organization primarily engaged in providing pain relief, symptom management, and supportive services to the terminally ill and their families. Congress authorized this benefit for 3 years beginning November 1, 1983. OBRA of 1985 made hospice care a permanent benefit on April 7, 1986, by removing the reference to the end date of this benefit. Medicare patients who qualify can receive a full range of medical and support services for their terminal condition. Hospice care is a comprehensive home-care program for the terminally ill. Medicare-covered services include physicians' services, skilled nursing care, medical appliances and supplies, outpatient drugs for symptom management and pain relief, home health aide and homemaker services, medical social services, counseling, and short-term inpatient care, including inpatient respite care.

To qualify for hospice benefits, a patient must have HI coverage, and his or her doctor and the hospice medical director must certify that the patient has a terminal illness and a prognosis of 6 or fewer months to live. Patients who elect this benefit must waive the standard Medicare HI benefits for services relevant to the terminal illness. Medicare will reimburse only hospice care provided by a Medicare-certified hospice. If the patient's attending physician is not employed by the hospice, SMI pays 80 percent of allowed charges after the deductible is met for physicians' services.

In fiscal year 1986, final bills were reimbursed for 11,185 terminally ill hospice patients who died in the fiscal year. (Conventional HI reimbursements are not included.) These reimbursements totaled $26.1 million, for an average of $2,337 per patient (unpublished data).

Under the hospice benefit, Medicare beneficiaries do not pay deductibles. Copayments may be collected by the hospice for only two items: a $5 maximum for each outpatient prescription for drugs and medications to manage symptoms and relieve pain and 5 percent of the cost for inpatient respite care up to the amount of the HI deductible. Respite care is a special benefit to provide a short-term inpatient stay to relieve family members or others primarily responsible for providing care to the patient at home.

Hospital use

Data on the use of and charges for inpatient hospital services are presented in Tables 3.9, 3.10, and 3.11. In 1984, there were 11.0 million Medicare inpatient hospital discharges (Table 3.9). These discharges resulted in covered charges of $52.9 billion for 96 million covered days of care. Short-stay hospital care accounted for 99 percent of all discharges and covered charges and for 98 percent of covered days of care. Aged enrollees, who represented 90 percent of all HI enrollees, used 89 percent of all covered days of care. Discharges per 1,000 enrollees, covered days of care per 1,000 enrollees, and average covered charges per enrollee were lower for the aged than the disabled.

In Tables 3.10 and 3.11, data are presented on the use of short-stay hospitals by aged and disabled enrollees, respectively. For both these groups, discharges per 1,000 enrollees and covered days of care per 1,000 increased with age. For all enrollees (aged and disabled combined), the discharge rate of men exceeded that of women. The discharge rate for both aged and disabled white persons exceeded that for persons of all other races. However, aged and disabled enrollees of other races had longer average lengths of stay and higher covered charges per discharge and per covered day of care than white enrollees. By region, both aged and disabled enrollees in the South had the highest discharge rate but the lowest covered charge per discharge. For both aged and disabled enrollees, the West had the highest covered charge per covered day of care but the lowest average length of stay.

In Table 3.12, the number of enrollees discharged from short-stay hospitals is shown by rank order for the 20 DRG's with the largest number of discharges in 1985. The rank order of the same DRG's in 1984 and total discharges for all DRG's are also shown. The total number of discharges decreased 9.1 percent, from 10.9 million in 1984 to 9.9 million in 1985. This was a substantial decrease.

The DRG system began in October 1983, and by the end of 1984, most short-stay hospitals were subject to it. From the start of the Medicare program, the number

Table 3.9

Use of inpatient hospital services by Medicare enrollees, by type of enrollee and type of hospital: Calendar year 1984

Type of enrollee and type of hospital	Discharges		Covered days of care			Covered charges			
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per 1,000 enrollees
All enrollees									
All hospitals	11,001	367	96,209	8.8	3,207	$52,884	$4,807	$550	$1,763
Short-stay	10,896	363	93,848	8.6	3,129	52,151	4,786	556	1,739
Long-stay	106	4	2,361	22.4	79	733	6,947	311	24
Psychiatric	60	2	1,304	21.9	43	322	5,407	247	11
All other	46	2	1,057	23.1	35	410	8,952	388	14
Aged									
All hospitals	9,770	360	85,303	8.7	3,146	46,838	4,794	549	1,728
Short-stay	9,705	358	83,758	8.6	3,089	46,320	4,773	553	1,708
Long-stay	65	2	1,545	23.7	57	518	7,930	335	19
Psychiatric	27	1	647	23.6	24	178	6,520	276	7
All other	38	1	898	23.7	33	339	8,951	377	12
Disabled									
All hospitals	1,231	427	10,905	8.9	3,781	6,047	4,913	554	2,096
Short-stay	1,191	413	10,090	8.5	3,498	5,832	4,898	578	2,022
Long-stay	40	14	815	20.3	283	215	5,353	264	75
Psychiatric	32	11	657	20.4	228	143	4,460	219	50
All other	8	3	158	19.8	55	72	8,957	451	25

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.10

Use of short-stay hospital inpatient services by aged Medicare enrollees, by demographic characteristics: Calendar year 1984

Characteristic	Aged hospital insurance enrollees in thousands[1]	Discharges		Covered days of care			Covered charges			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	27,112	9,705	358	83,758	8.6	3,089	$46,320	$4,773	$553	$1,708
Age										
65–66 years	3,584	879	245	6,879	7.8	1,919	4,168	4,740	606	1,163
67–68 years	3,414	921	270	7,397	8.0	2,167	4,419	4,801	597	1,294
69–70 years	3,253	966	297	7,948	8.2	2,443	4,699	4,863	591	1,445
71–72 years	2,940	954	324	7,981	8.4	2,714	4,650	4,875	583	1,581
73–74 years	2,614	925	354	7,890	8.5	3,018	4,524	4,889	573	1,731
75–79 years	5,192	2,084	401	18,258	8.8	3,516	10,062	4,828	551	1,938
80–84 years	3,343	1,564	468	14,173	9.1	4,240	7,355	4,702	519	2,200
85 years or over	2,771	1,411	509	13,232	9.4	4,775	6,442	4,566	487	2,324
Sex										
Male	10,920	4,171	382	35,192	8.4	3,223	20,955	5,024	595	1,919
Female	16,192	5,534	342	48,566	8.8	2,999	25,365	4,584	522	1,567
Race[2]										
White	23,945	8,647	361	73,713	8.5	3,078	40,568	4,692	550	1,694
Other	2,374	795	335	7,763	9.8	3,270	4,477	5,634	577	1,886
Census region										
Northeast	6,241	2,132	342	22,806	10.7	3,654	11,590	5,437	508	1,857
North Central	6,979	2,594	372	21,878	8.4	3,135	11,882	4,581	543	1,702
South	8,736	3,444	394	27,977	8.1	3,203	14,570	4,230	521	1,668
West	4,614	1,472	319	10,540	7.2	2,285	8,112	5,511	770	1,758

[1] As of July 1, 1984.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.11

Use of short-stay hospital inpatient services by disabled Medicare enrollees, by demographic characteristics: Calendar year 1984

Characteristic	Disabled hospital insurance enrollees in thousands[1]	Discharges		Covered days of care			Covered charges			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	2,884	1,191	413	10,090	8.5	3,498	$5,832	$4,898	$577	$2,022
Age										
Under 35 years	388	127	327	1,121	8.8	2,886	627	4,932	559	1,614
35–44 years	422	146	347	1,260	8.6	2,985	696	4,750	552	1,648
45–54 years	584	248	424	2,050	8.3	3,509	1,166	4,703	568	1,996
55–59 years	581	262	451	2,195	8.4	3,775	1,283	4,890	584	2,207
60–64 years	908	407	448	3,465	8.5	3,814	2,060	5,065	594	2,268
Sex										
Male	1,830	701	383	5,817	8.3	3,178	3,464	4,941	595	1,893
Female	1,054	489	464	4,274	8.7	4,054	2,368	4,837	554	2,246
Race[2]										
White	2,326	961	413	8,019	8.3	3,448	4,566	4,750	569	1,963
Other	502	207	412	1,878	9.1	3,739	1,151	5,560	612	2,292
Census region										
Northeast	604	238	395	2,446	10.3	4,052	1,343	5,632	549	2,226
North Central	660	285	432	2,497	8.8	3,781	1,427	5,002	571	2,162
South	1,053	479	455	3,784	7.9	3,595	2,023	4,222	534	1,922
West	460	176	383	1,273	7.2	2,765	1,008	5,716	791	2,189

[1] As of July 1, 1984.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.12

Short-stay hospital discharges, by rank order of the 20 diagnosis-related groups with the most discharges in 1985: Calendar years 1984 and 1985

Diagnosis-related group number and description	1985			1984		
	Discharges		Average length of stay in days	Discharges		Average length of stay in days
	Number in thousands	Rank order		Number in thousands	Rank order	
All diagnosis-related groups	9,900.7	NA	8.6	10,895.6	NA	8.9
20 leading diagnosis-related groups	4,169.0	NA	8.6	4,297.5	NA	9.2
127 Heart failure and shock	493.4	1	8.2	515.9	1	8.7
140 Angina pectoris	345.1	2	5.2	330.0	4	5.6
089 Simple pneumonia and pleurisy, age greater than 69 and comorbidity or complications	343.9	3	9.0	315.0	6	9.4
182 Esophagitis, gastroenteritis, and miscellaneous digestive disorders, age greater than 69 and comorbidity or complications	310.1	4	5.9	372.6	2	6.1
014 Specific cerebrovascular disorders except transient ischemic attack	308.5	5	11.2	318.5	5	12.5
138 Cardiac arrhythmia and conduction disorders, age greater than 69 and comorbidity or complications	207.4	6	6.0	212.3	8	6.4
296 Nutritional and miscellaneous metabolic disorders, age greater than 69 and comorbidity or complications	205.9	7	7.7	176.2	11	8.4
096 Bronchitis and asthma, age greater than 69 and comorbidity or complications	185.2	8	7.0	178.1	10	7.2
088 Chronic obstructive pulmonary disease	170.5	9	8.2	212.5	7	8.7
243 Medical back problems	167.2	10	7.3	200.2	9	8.0
015 Transient ischemic attacks	166.2	11	5.7	175.5	12	6.1
209 Major joint procedures	162.8	12	14.2	149.7	16	15.7
336 Transurethral prostatectomy, age greater than 69 and comorbidity or complications	159.1	13	7.1	153.3	15	7.9

See footnotes at end of table.

Table 3.12—Continued

Short-stay hospital discharges, by rank order of the 20 diagnosis-related groups with the most discharges in 1985: Calendar years 1984 and 1985

Diagnosis-related group number and description	1985			1984		
	Discharges		Average length of stay in days	Discharges		Average length of stay in days
	Number in thousands	Rank order		Number in thousands	Rank order	
174 Gastrointestinal hemorrhage, age greater than 69 and comorbidity or complications	149.2	14	6.9	144.6	17	7.5
468 Unrelated operating room procedure	148.7	15	15.3	166.8	13	16.7
122 Circulatory disorders with acute myocardial infarction, without cardiovascular complications, discharged alive	141.3	16	9.3	158.4	14	10.3
320 Kidney and urinary tract infections, age greater than 69 and comorbidity or complications	138.9	17	8.0	137.8	19	8.2
430 Psychoses	127.5	18	16.4	118.5	22	16.1
210 Hip and femur procedures except major joint, age greater than 69 and comorbidity or complications	119.6	19	15.1	120.1	21	16.8
294 Diabetes, age 36 or greater	118.4	20	8.0	141.5	18	8.4

NOTE: Discharge figures for 1984 differ from those in Table 2.10 because they were derived from different data sources and different processing cutoff dates.
SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Office of Research.

of discharges from short-stay hospitals increased each year until 1983 (Table 2.10). The reasons for the 1984–85 decrease are unclear, but it may be related to greater use of hospital outpatient care and care from other types of providers. The average length of stay also fell, from 8.9 days in 1984 to 8.6 days in 1985. The average length of stay for hospitals under the prospective payment system was unchanged, 7.8 days in both 1984 and 1985 (unpublished data). Reimbursements for short-stay hospital services increased from $38.5 billion to $40.2 billion in the 1984–85 period. The $1.7 billion increase was the smallest increase in the 1980's.

The rank order of 18 of the 20 leading DRG's also changed from 1984 to 1985. Heart failure and shock (DRG 127) ranked first in both years. Angina pectoris (DRG 140) moved from fourth place in 1984 to second place in 1985.

Skilled nursing facility use

HI covers services in participating skilled nursing facilities for up to 100 days in a benefit period. For the first 20 days, patients pay no coinsurance. The remaining 80 days require coinsurance equal to one-eighth of the inpatient deductible ($65 in 1987). A beneficiary is eligible for SNF benefits only after hospitalization for at least 3 consecutive days and only if the transfer to an SNF occurs within 30 days after a hospital discharge.

Data on the use of SNF's by aged and disabled enrollees in 1984 are reported in Table 3.13. Information on persons served and reimbursements is shown by age, sex, race, and region. Overall, a much higher proportion of aged than disabled enrollees received SNF benefits—10.7 persons served per 1,000 aged enrollees, compared with 3.1 per 1,000 disabled enrollees. Reimbursements per person served, however, were 6 percent higher for the disabled than the aged. For both aged and disabled enrollees, the number of persons served per 1,000 enrollees increased with age. Among both the aged and the disabled, higher proportions of females than males received SNF benefits. For aged enrollees, rates per 1,000 enrollees were much higher among white persons than among all other persons, but reimbursements per person served were higher for all other persons than white persons. The number of persons served per 1,000 aged and disabled enrollees was lowest in the South and highest in the West. Reimbursements per person served were lowest in the South and North Central regions for both aged and disabled enrollees.

Home health agency use

The third type of benefit covered by HI is home health agency services for persons under the care of a physician, confined to the home, and needing part-time or intermittent skilled nursing care or therapy. Covered services include skilled nursing care; physical, occupational, or speech therapy; part-time or intermittent services of a home health aide; medical supplies (other than drugs and biologicals); the use of medical appliances; and, in certain cases, services of an intern or resident. The services must be furnished by an approved HHA.

In Table 3.14, data are presented on the use of HHA services in 1984. The number of HHA visits per enrollee was 27 percent greater for the aged than the disabled. Because reimbursements per visit were similar for both groups, reimbursements per enrollee were 25 percent higher for the aged, $56, than for the disabled, $45. Females had higher proportions of both visits per enrollee and reimbursements per enrollee than males. White persons had lower visits per enrollee and lower reimbursements per enrollee than persons of other races.

Table 3.13

Use of skilled nursing facilities by aged and disabled Medicare enrollees, by demographic characteristics: Calendar year 1984

Type of enrollee and characteristic	Hospital insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Aged						
Total	27,111.6	289.8	10.7	$457.8	$1,580	$16.89
Age:						
65–69 years	8,654.0	24.6	2.8	44.3	1,798	5.12
70–74 years	7,151.2	44.4	6.2	70.4	1,586	9.84
75–79 years	5,192.0	59.7	11.5	96.8	1,620	18.64
80–84 years	3,342.9	66.1	19.8	102.9	1,657	30.78
85 years or over	2,771.4	95.0	34.3	143.5	1,510	51.78
Sex:						
Male	10,919.5	90.4	8.3	136.8	1,513	12.53
Female	16,192.0	199.4	12.3	321.0	1,610	19.82
Race:[2]						
White	23,945.1	264.8	11.1	414.7	1,566	17.32
Other	2,374.0	17.5	7.4	31.4	1,796	13.23
Census region:						
Northeast	6,240.5	61.0	9.8	109.8	1,799	17.59
North Central	6,979.1	90.5	13.0	136.5	1,508	19.56
South	8,735.9	71.0	8.1	101.5	1,429	11.62
West	4,613.9	66.9	14.5	109.6	1,637	23.75
Disabled						
Total	2,884.4	8.9	3.1	15.0	1,675	5.20
Age:						
Under 35 years	388.2	0.5	1.2	0.8	1,717	2.06
35–44 years	422.2	0.6	1.5	1.0	1,559	2.37
45–54 years	584.2	1.5	2.6	2.7	1,753	4.62
55–59 years	581.3	2.1	3.6	3.4	1,622	5.85
60–64 years	908.4	4.2	4.6	7.1	1,687	7.82
Sex:						
Male	1,830.2	4.6	2.5	7.8	1,707	4.26
Female	1,054.2	4.3	4.1	7.1	1,642	6.73
Race:[2]						
White	2,325.9	7.5	3.2	12.4	1,665	5.33
Other	502.2	1.3	2.6	2.3	1,752	4.58
Census region:						
Northeast	603.5	1.5	2.5	3.0	1,977	4.97
North Central	660.2	2.8	4.3	4.5	1,588	6.82
South	1,052.5	2.4	2.3	3.6	1,479	3.42
West	460.3	2.1	4.6	3.8	1,822	8.26

[1] As of July 1, 1984.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.14

Medicare visits, charges, and reimbursements for home health agency services, by type of enrollee, sex, and race: Calendar year 1984

Type of enrollee, sex, and race	Visits		Charges			Reimbursements		
	Number in millions	Per 1,000 enrollees	Amount in millions	Amount in millions for visits[1]	Amount per visit[1]	Amount in millions	Per visit	Per enrollee
Total	40.3	1,324	$1,982.0	$1,843.7	$45.71	$1,666.3	$41.31	$54.71
Type of enrollee								
Aged	37.3	1,351	1,827.4	1,703.3	45.71	1,537.5	41.26	55.77
Disabled	3.1	1,067	154.6	140.4	45.62	128.8	41.86	44.65
Sex								
Male	14.2	1,101	706.0	651.7	45.98	590.3	41.65	45.85
Female	26.2	1,488	1,276.0	1,192.0	45.56	1,075.9	41.13	61.20
Race[2]								
White	33.8	1,273	1,645.8	1,535.9	45.39	1,389.0	41.05	52.26
Other	5.4	1,810	284.0	259.6	47.80	233.4	42.98	77.80

[1] Excludes durable medical equipment and supplies, except for drugs and biologicals, furnished by home health agencies.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Supplementary medical insurance

The SMI program covers physicians' services, including visits to the home, office, hospital, and other institutions. The program also pays for other services and supplies, such as drugs and biologicals that cannot be self-administered, if they are furnished as part of a physician's professional services; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy; splints, casts, and other devices used for reduction of fractures and dislocations; purchase or rental of durable medical equipment; ambulance services; and prosthetic devices that replace all or part of a body organ. In addition, SMI pays for outpatient services received in hospitals, rural health centers, community health centers, and renal dialysis centers as well as outpatient rehabilitation, speech therapy, and physical therapy services. The 1972 amendments, effective July 1, 1973, provide for coverage of services of physical therapists in independent practice furnished in their office or the patient's home if the services are under a physician's plan. The reimbursement limit for these services was increased from $100 to $500 by the 1980 Omnibus Budget Reconciliation Act. Lastly, limited chiropractic and optometric services are also covered.

During each calendar year, enrollees must exceed the SMI deductible to be reimbursed. From 1973 through 1981, the annual deductible was $60 of reasonable charges; beginning in 1982, it was increased to $75.

After the deductible is met, SMI pays 80 percent of the allowed (reasonable) charges for covered physicians' services and most other medical services. The allowed charge is determined for each specific service and is the lowest of:

- The physician's actual charge for the service.
- The physician's customary charge for the service (the physician's 50th percentile charge level for the specific type of service).
- The prevailing charge, which is set at the 75th percentile of the customary charges for the service charged by the physicians in an area defined by the carrier.

Increases in the prevailing charge are limited by the Medicare Economic Index (mandated by the 1972 Amendments to the Social Security Act). The percent increase in the Index is the maximum allowable increase in the prevailing charge for a physician's service. This percentage is based on the weighted averages of changes in general earnings levels, changes in expenses incurred by physicians in office practice, and general inflation.

Physicians can accept or reject assignment. Accepting assignment means that a participating physician submits the bill to the carrier and agrees to accept 80 percent of the reasonable charge. The patient is responsible for the deductible and the remaining 20 percent of the reasonable charge. The nonparticipating physician does not accept assignment and bills the patient. The patient is responsible for the physician's total charge. The patient submits the bill to the carrier. The carrier pays the patient 80 percent of the reasonable charge after the deductible is met.

The Deficit Reduction Act (DEFRA) of 1984 was an effort to contain Medicare physician charges. For the 15 months beginning July 1, 1984, DEFRA froze Medicare customary, prevailing, and actual charges for physicians'

services at the levels that were in effect for the 12 months ending June 30, 1984. Congress later extended the freeze on customary and prevailing charges and on nonparticipating physicians' actual charges through April 1, 1986 (Omnibus Budget Reconciliation Act of 1985, Public Law 99-272).

Physicians who serve Medicare patients can choose to be participating or nonparticipating physicians. Participating physicians voluntarily sign an agreement to accept assignment for all services provided to Medicare patients for a year. Nonparticipating physicians may accept assignment on a claim-by-claim basis. Medicare furnishes incentives for physician participation, including directories of participating physicians, dissemination of the names of participating physicians by toll-free telephone lines, and electronic receipt of claims by carriers.

Participating physicians were allowed to make normal increases in their actual charges to Medicare patients during the freeze period. These normal increases did not affect Medicare payments during the freeze but were recognized by Medicare in calculations of customary charges of participating physicians after the freeze ended. Nonparticipating physicians were not permitted to increase their actual billed charges to Medicare patients during the freeze.

What effect did DEFRA have on assignment rates? Assignment rates are based on total charges of assigned claims as a percent of total charges submitted by physicians. The assignment rate rose from 55.6 percent in 1983 to 68.6 percent in 1985, an unusually large increase, primarily because of incentives to participating physicians provided by DEFRA (McMillan, Lubitz, and Newton, 1986). This was the most rapid increase in assignment rates since HCFA began collecting such charge data.

Beginning July 1, 1984, DEFRA also modified the assignment and billing options for clinical diagnostic laboratory tests. It established a fee schedule based on a percent of prevailing charges. Tests furnished by independent laboratories, independent hospital laboratories (those furnishing tests to nonhospital patients), and physicians who accept assignment are reimbursed at 100 percent of the fee schedule. Charges of independent and hospital laboratories (which must accept assignment) and participating physicians are not subject to an SMI deductible or coinsurance. Physicians not accepting assignment for laboratory tests are paid 80 percent of the fee schedule, subject to the SMI deductible and coinsurance. Outpatient treatment for mental illness is also subject to the deductible and coinsurance; benefits are limited to the lesser of 50 percent of reasonable charges or $250.

In Table 3.15, SMI data on average charges and reimbursements per enrollee are reported. Data are presented for the period 1967-84 by type of enrollee. Reimbursements were estimated by subtracting deductible and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceeded reasonable charges were excluded.

In 1967, the program reimbursed only 58 percent of reasonable costs or charges to aged enrollees. (Reimbursements are 80 percent of reasonable charges after subtracting the SMI deductible.) Reasonable costs or charges were $108.58 per aged enrollee in 1967, and reimbursements were $62.51 per enrollee. Reasonable charges per aged enrollee rose 686 percent from 1967 to 1984; the SMI deductible rose only 50 percent in the same period (from $50 to $75 a year). Because the deductible became smaller in relation to reasonable charges, reimbursements as a percent of reasonable charges increased. In 1974 (the first full year of coverage for the disabled), Medicare reimbursed 68 percent of reasonable costs or charges to the disabled. By 1984, the comparable figure for both the aged and the disabled had risen to 75 percent. Physicians' services made up the major share of SMI reimbursements in 1984, comprising 81 percent of reimbursement for the aged and 79 percent for the disabled. By 1982, HHA services were reimbursed at 100 percent of reasonable costs. Although most HHA services were covered under the HI program, aged enrollees covered only by SMI use HHA services under the SMI program.

In Tables 3.16 and 3.17, data are provided on physicians' and other medical services used in 1984 by aged and disabled enrollees, respectively. The number of persons served per 1,000 enrollees was 4 percent higher for aged enrollees (677) than for disabled enrollees (649). However, reimbursement per person served was 23 percent higher for disabled enrollees ($900 versus $729). As a result, reimbursements per enrollee were 18 percent higher for disabled than aged enrollees.

For physicians' services, the number of persons served per 1,000 enrollees was higher for older age groups among both aged and disabled enrollees. Reimbursement per aged person served generally increased with age. Proportionately more women than men received benefits in both enrollee groups, although reimbursement per person served was 20 percent higher for aged men than for aged women. Among the disabled, average reimbursements per person served were similar for both sexes. Among both the aged and the disabled, the number of persons served per 1,000 enrollees was higher for white persons than for all other persons, but reimbursement per person served was lower for white persons. Data by region show that aged and disabled enrollees living in the West had the highest amount reimbursed per person served.

Data on total physicians' charges, reasonable charges as determined by carriers, and amounts reimbursed by Medicare in 1984 are shown in Table 3.18 for aged and disabled enrollees combined. Medicare carriers reduced physicians' total charges by 26 percent, with little variation by region. The percent reduction was highest in the Northeast and lowest in the West. Medicare reimbursed 55.3 percent of physicians' charges after carriers made reasonable charge reductions and subtracted deductible and coinsurance amounts. The proportion of reimbursements to physician charges differed only slightly by region.

Table 3.15

Average reasonable charge or cost and reimbursement per enrollee for supplementary medical insurance (SMI), by type of service and type of enrollee: Years ending June 30, 1967–84

Type of enrolleee and year	Average enrollment in thousands	All services		Physicians' services[1]		Outpatient services		Home health agency services		Health care prepayment plan services		Independent laboratory services	
		Reasonable cost or charge	Reimbursement	Reasonable charge	Reimbursement	Reasonable cost	Reimbursement	Reasonable cost	Reimbursement	Reasonable cost or charge	Reimbursemwnr	Reasonable cost or charge	Reimbursement
						Amount							
Aged													
1967	17,750	$108.58	$62.51	$102.70	$59.12	$2.45	$1.41	$1.37	$0.79	$1.54	$0.89	$0.52	$0.30
1968	18,038	128.08	80.06	119.02	74.47	3.89	2.40	2.42	1.49	2.18	1.35	0.57	0.35
1969	18,833	145.17	93.71	131.91	85.47	6.93	4.31	3.15	1.96	2.53	1.57	0.65	0.40
1970	19,312	153.63	99.91	137.86	90.03	9.43	5.91	3.17	1.99	2.40	1.50	0.77	0.48
1971	19,664	162.10	106.25	144.41	95.05	11.89	7.53	2.64	1.67	2.21	1.40	0.95	0.60
1972	20,043	172.75	114.22	153.15	101.63	13.32	8.55	2.49	1.60	2.58	1.66	1.21	0.78
1973	20,428	186.20	122.38	163.99	107.98	14.78	9.42	3.02	2.17	2.94	1.87	1.47	0.94
1974	20,988	204.30	134.47	178.31	117.48	17.75	11.32	2.54	2.03	3.82	2.44	1.88	1.20
1975	21,504	236.78	160.42	201.23	136.28	23.50	15.45	4.66	3.83	4.90	3.22	2.49	1.64
1976	22,089	272.26	188.80	225.42	156.27	31.61	21.26	6.18	5.19	6.04	4.06	3.01	2.02
1977	22,605	313.51	221.61	253.78	179.29	41.76	28.68	7.60	6.52	6.77	4.65	3.60	2.47
1978	23,133	354.59	254.45	288.61	207.05	47.85	33.38	7.82	6.82	6.13	4.28	4.18	2.92
1979	23,693	399.08	289.77	322.16	233.99	57.28	40.52	7.76	6.86	7.20	5.09	4.68	3.31
1980	24,287	466.29	343.45	376.29	277.24	65.46	47.06	8.44	7.58	10.45	7.51	5.65	4.06
1981	24,826	545.95	407.95	438.81	328.15	77.67	56.69	8.80	8.03	13.28	9.69	7.39	5.39
1982	25,363	627.73	464.29	513.63	381.02	88.73	64.65	0.50	0.50	15.99	11.65	8.88	6.47
1983	25,873	749.28	555.06	613.47	454.88	105.60	77.74	0.77	0.77	19.47	14.33	9.97	7.34
1984	26,433	853.03	636.34	686.61	512.35	129.47	96.26	0.99	0.99	23.68	17.61	12.28	9.13
Disabled[2]													
1974	1,638	170.09	115.88	143.28	97.48	21.02	13.89	4.18	3.45	0.47	0.31	1.14	0.75
1975	1,816	210.84	148.45	178.39	125.50	25.28	17.32	4.18	3.58	1.17	0.80	1.82	1.25
1976	2,018	248.50	177.47	207.63	148.10	31.28	21.70	5.91	5.12	1.17	0.81	2.51	1.74
1977	2,231	301.42	218.79	240.18	174.48	51.48	36.44	5.41	4.79	1.06	0.75	3.29	2.33
1978	2,423	347.69	254.76	276.23	202.59	59.84	42.76	6.20	5.54	1.33	0.95	4.09	2.92
1979	2,563	404.58	299.87	323.87	240.40	69.72	50.49	5.66	5.12	0.49	0.35	4.84	3.51
1980	2,641	480.87	360.66	383.75	288.17	82.74	60.72	6.63	6.08	2.06	1.51	5.69	4.18
1981	2,687	568.64	431.25	447.87	340.16	103.93	77.15	7.77	7.21	2.14	1.59	6.93	5.14
1982	2,685	678.22	509.98	523.03	394.80	144.04	106.90	([3])	([3])	2.41	1.79	8.74	6.49
1983	2,628	826.35	621.91	643.11	484.74	169.73	127.06	([3])	([3])	2.65	1.98	10.86	8.13
1984	2,593	884.39	665.96	699.62	527.21	169.01	126.92	([3])	([3])	2.61	1.96	13.15	9.87

[1] Figures vary from those in Tables 3.16 and 3.17, as explained in the Note. Also, data in Tables 3.16 and 3.17 are for physicians' and other medical services; these data are for physicians' services only.

[2] Excludes enrollees with end stage renal disease only.

[3] The Omnibus Budget Reconciliation Act of 1980 removed the 3-day hospital stay as a precondition for home health agency benefits under hospital insurance (HI). The act provides that services previously paid for by HI and SMI will now be paid for by HI.

NOTE: Figures vary from those in other tables in this report. These figures are actuarial estimates from a 0.1-percent sample of all aged enrollees and a 1.0-percent sample of all disabled enrollees. Reimbursements are estimated by subtracting deductibles and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceed amounts the program deems reasonable are excluded.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1987 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U.S. Government Printing Office, Mar. 31, 1987.

Table 3.16

Use of physicians' and other medical services by aged Medicare enrollees, by demographic characteristics: Calendar year 1984

Characteristic	Aged supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	26,764.2	18,127.9	677.3	$13,218.0	$729.15	$493.87
Age						
65–69 years	8,499.5	5,163.9	607.6	3,354.7	649.63	394.69
70–74 years	7,133.7	4,701.7	659.1	3,445.6	732.83	483.00
75–79 years	5,205.7	3,701.8	711.1	2,890.1	780.73	555.18
80–84 years	3,294.8	2,475.2	751.2	1,956.9	790.59	593.94
85 years or over	2,630.5	2,085.3	792.7	1,570.7	753.23	597.11
Sex						
Male	10,652.4	6,857.3	643.7	5,586.1	814.62	524.40
Female	16,111.7	11,270.6	699.5	7,631.8	677.14	473.68
Race[2]						
White	23,619.3	16,127.6	682.8	11,746.5	728.34	497.33
Other	2,358.0	1,480.7	628.0	1,096.7	740.65	465.10
Census region						
Northeast	6,223.1	4,350.8	699.1	3,178.5	730.56	510.76
North Central	6,944.5	4,633.3	667.2	3,119.4	673.24	449.19
South	8,734.7	5,825.8	667.0	4,074.9	699.46	466.52
West	4,600.5	3,213.0	698.4	2,794.7	869.81	607.48

[1] As of July 1, 1984.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.17

Use of physicians' and other medical services by disabled Medicare enrollees, by demographic characteristics: Calendar year 1984

Characteristic	Disabled supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,651.2	1,721.5	649.3	$1,548.9	$899.75	$584.23
Age						
Under 35 years	358.0	198.1	553.4	173.1	873.89	483.52
35–44 years	382.3	222.8	582.6	194.4	872.64	508.50
45–54 years	530.0	340.8	643.0	312.6	917.06	589.81
55–59 years	534.1	359.8	673.6	333.7	927.31	624.79
60–64 years	846.8	600.0	708.5	535.2	891.99	632.03
Sex						
Male	1,663.9	992.8	596.7	878.0	884.39	527.68
Female	987.4	728.7	738.0	670.9	920.67	679.46
Race[2]						
White	2,134.3	1,396.7	654.4	1,237.3	885.89	579.72
Other	463.8	291.6	628.7	281.2	964.23	606.30
Census region						
Northeast	561.6	379.7	676.1	338.2	890.71	602.21
North Central	614.3	404.9	659.1	353.7	873.69	575.78
South	990.2	615.4	621.5	516.1	838.66	521.21
West	432.1	301.7	698.1	330.5	1,095. 70	764.87

[1] As of July 1, 1984.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.18

Physicians' charges and Medicare reimbursements, by census region: Calendar year 1984

Census region	Charges		Percent reduction in total charges	Reimbursements	
	Total	Reasonable		Amount in millions	As percent of total charges
	Amount in millions				
United States	$25,163	$18,540	26.3	$13,909	55.3
Northeast	6,391	4,566	28.6	3,375	52.8
North Central	5,816	4,341	25.4	3,250	55.9
South	8,049	5,881	26.9	4,429	55.0
West	4,907	3,752	23.5	2,855	58.2

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Office of Research.

In Figure 3.1 is shown the distribution of total physicians' charges due (total charges less the reduction amount on assigned claims) between the amount paid by Medicare and the amount of beneficiary liability. In 1984, among aged persons served, Medicare reimbursed 67.3 percent of total physicians' charges due. The remainder, 32.7 percent, comprised the coinsurance (14.7 percent), the reduction on unassigned claims (11.3 percent), and the deductible (6.7 percent). The proportion reimbursed for disabled persons served was 70.4 percent, somewhat higher than that of the aged.

Data on outpatient services provided to aged and disabled enrollees are presented in Tables 3.19 and 3.20. In 1984, reimbursements totaled $2.8 billion for aged enrollees and $941 million for disabled enrollees. The disabled accounted for 25 percent of total reimbursements for outpatient services, although they represented 10 percent of all enrollees. The number of persons served per 1,000 enrollees was higher for disabled than for aged enrollees. Reimbursement per person served was 2.9 times as great for the disabled ($915) as for the aged ($319). By age, the highest amount reimbursed per person served was $1,303 for disabled enrollees under age 35. This large reimbursement reflects the relatively high proportion of disabled persons with end stage renal disease in this age group.

For outpatient services, the number of persons served per 1,000 aged enrollees was 7 percent greater for females, but males had a 15-percent greater reimbursement per person served. As a result, reimbursements per enrollee was 7 percent greater among males. Aged persons of races other than white had a user rate 3 percent higher than the rate for aged white persons and a 47-percent higher reimbursement per person served, resulting in a 52-percent higher reimbursement per enrollee for all other persons.

Data on outpatient service use among disabled enrollees show that females had both higher proportions using reimbursed services and higher reimbursements per person served than males. The combined effect was a 40-percent higher reimbursement per enrollee among disabled females than males. Differences were even more striking by race. A smaller proportion of white persons than all other persons used outpatient services, and white persons also had much lower reimbursements per person served. This resulted in an average reimbursement per enrollee for all other persons that was 123 percent higher than that of white persons.

Data on covered hospital outpatient charges and reimbursements in 1984 for aged and disabled enrollees (including those with ESRD) are shown in Table 3.21 by census region. The proportions of charges reimbursed were 65.9 percent for aged enrollees and 72.7 percent for disabled enrollees. The amount reimbursed per enrollee was 242 percent greater for the disabled, primarily because most ESRD patients are included among the disabled. Reimbursements per enrollee were lowest in the South and highest in the West for both aged and disabled enrollees. The percent of charges reimbursed was highest in the West and lowest in the Northeast.

Financing

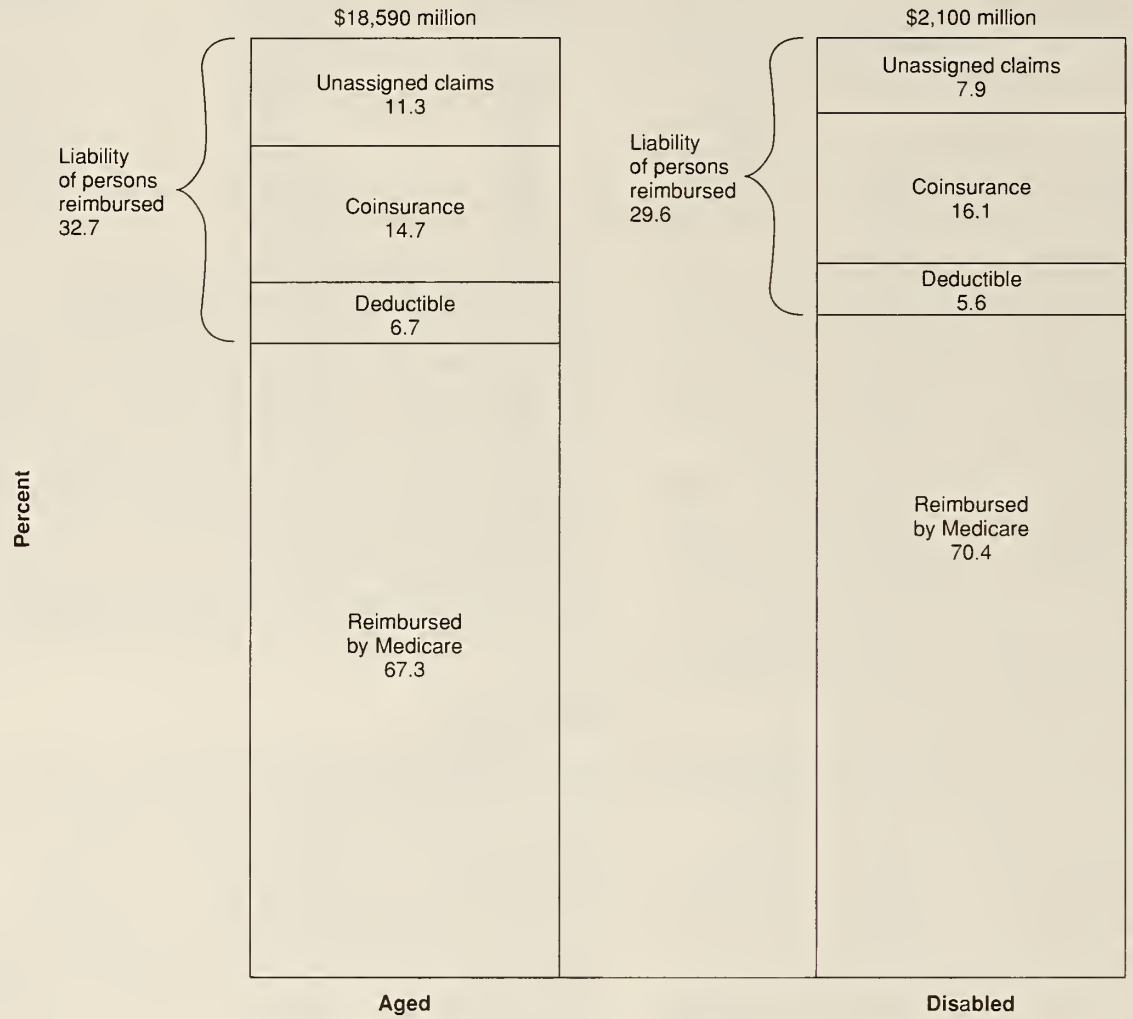
HI is financed primarily through a tax on a portion of current employment earnings covered under the Social Security Act. Other sources of income for the program (shown in Table 3.22) include proceeds from the railroad retirement system, income to the trust fund appropriated from general revenues to reimburse the program for costs of transitionally insured persons, and interest earned by the fund. These monies are earmarked for the HI trust fund to pay benefits and administrative expenses.

In 1984, payroll taxes accounted for 91 percent of the HI trust fund's total income. In the 1960's, the payroll tax share fluctuated from a high of 96 percent in 1966 to a low of 78 percent in 1968. Since 1968, benefit payments have accounted for 97 percent or more of all HI disbursements.

The Federal SMI trust funds (Table 3.23) come from premiums paid by or on behalf of SMI enrollees, contributions of the Federal Government from the general fund of the Treasury, and interest from investments of the fund. When Medicare began, the monthly SMI premium was $3. As of January 1, 1987, the premium had risen to $17.90 per month. Until 1973, premiums were set to finance one-half of the benefit and administrative costs of the SMI program plus a contingency amount. General revenues financed the other half. The 1972 amendments altered that arrangement. Beginning July 1973, monthly premiums can be raised only if monthly social security cash benefits are increased. Furthermore, premiums are permitted to rise no more than the percentage increase in

Figure 3.1

Percent distribution of physicians' charges due for Medicare aged and disabled persons reimbursed: Calender year 1984



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Information Analysis.

Table 3.19

Use of outpatient services by aged Medicare enrollees, by age, sex, and race: Calendar year 1984

Age, sex, and race	Aged supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	26,764.2	8,743.4	326.7	$2,790.1	$319.11	$104.25
Age						
65–69 years	8,499.5	2,491.1	293.1	803.3	322.45	94.51
70–74 years	7,133.7	2,278.7	319.4	761.0	333.97	106.68
75–79 years	5,205.7	1,792.4	344.3	599.6	334.53	115.18
80–84 years	3,294.8	1,179.5	358.0	363.2	307.95	110.23
85 years or over	2,630.5	1,001.7	380.8	263.0	262.52	99.98
Sex						
Male	10,652.4	3,344.7	314.0	1,158.9	346.49	108.79
Female	16,111.7	5,398.7	335.1	1,631.2	302.14	101.24
Race[2]						
White	23,619.3	7,703.7	326.2	2,354.9	305.68	99.70
Other	2,358.0	793.9	336.7	356.3	448.76	151.10

[1] As of July 1, 1984.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.20

Use of outpatient services by disabled Medicare enrollees, by age, sex, and race: Calendar year 1984

Age, sex, and race	Disabled supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,651.2	1,028.5	387.9	$941.4	$915.32	$335.09
Age						
Under 35 years	358.0	137.8	384.9	179.5	1,302.64	501.40
35–44 years	382.3	146.3	382.7	169.5	1,158.50	443.37
45–54 years	530.0	209.3	394.9	212.7	1,016.36	401.32
55–59 years	534.1	208.6	390.6	166.5	798.20	311.74
60–64 years	846.8	326.5	385.6	213.2	652.92	251.77
Sex						
Male	1,663.9	583.8	350.9	514.2	880.74	309.03
Female	987.4	444.7	450.4	427.2	960.71	432.65
Race[2]						
White	2,134.3	810.9	379.0	620.5	765.13	290.73
Other	463.8	198.9	428.8	300.8	1,512.56	648.56

[1] As of July 1, 1984.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.21

Hospital outpatient charges and Medicare reimbursements, by type of enrollee and census region: Calendar year 1984

Census region	Covered charges in millions		Reimbursements					
			Amount in millions		Per enrollee		As percent of covered charges	
	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
All areas	$4,029.7	$1,236.8	$2,656.3	$899.2	$99.25	$339.17	65.9	72.7
United States	4,018.6	1,220.4	2,648.8	886.7	99.88	340.95	65.9	72.7
Northeast	1,116.4	323.5	688.4	227.2	110.62	404.49	61.7	70.2
North Central	1,005.9	259.7	680.8	190.5	98.03	310.11	67.7	73.4
South	1,070.5	399.4	717.6	293.9	82.15	296.81	67.0	73.6
West	825.8	237.7	562.0	175.1	122.16	405.23	68.1	73.7

NOTE: Includes end stage renal disease enrollees.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Statistics and Data Management.

Table 3.22

Operations of the Medicare hospital insurance trust fund: Calendar years 1966–84

Year	Income							Disbursements			Trust fund	
	Total income	Payroll taxes	Transfers from railroad retirement account	Reimbursement for transitionally insured persons	Premiums from voluntary enrollees	Reimbursement for military wage credits	Interest on investments and other income[1]	Total disbursements	Benefit payments[2]	Administrative expenses[3]	Net change	Yearend balance
	Amount in millions											
1966	$1,943	$1,858	$16	$26	NA	$11	$32	$999	$891	$108	$+944	$944
1967	3,559	3,152	44	301	NA	11	51	3,430	3,353	77	+129	1,073
1968	5,287	4,116	54	1,022	NA	22	74	4,277	4,179	99	+1,010	2,083
1969	5,279	4,473	64	617	NA	11	113	4,857	4,739	118	+422	2,505
1970	5,979	4,881	66	863	NA	11	158	5,281	5,124	157	+698	3,202
1971	5,732	4,921	66	503	NA	48	193	5,900	5,751	150	−168	3,034
1972	6,403	5,731	63	381	NA	48	180	6,503	6,318	185	−99	2,935
1973	10,821	9,944	99	451	$2	48	278	7,289	7,057	232	+3,352	6,467
1974	12,024	10,844	132	471	5	48	523	9,372	9,099	272	+2,652	9,119
1975	12,980	11,502	138	621	7	48	664	11,581	11,315	266	+1,399	10,517
1976	13,766	12,727	143	[4]0	9	141	746	13,679	13,340	339	+88	10,605
1977	15,856	14,114	[5]0	[4]803	12	[6]143	784	16,019	15,737	283	−163	10,442
1978	19,213	17,324	[5]214	688	13	141	834	18,178	17,682	496	+1,035	11,477
1979	22,825	20,768	191	734	16	141	975	21,073	20,623	450	+1,751	13,228
1980	26,097	23,848	244	697	18	141	1,149	25,577	25,064	512	+521	13,749
1981	35,725	32,959	276	659	22	207	1,603	30,726	30,342	384	+4,999	18,748
1982	37,998	34,586	351	808	24	207	2,022	36,144	35,631	513	−10,583	8,164
1983	44,570	37,259	358	878	27	[7]3,456	2,593	39,877	39,337	540	+4,693	12,858
1984	46,720	42,288	351	752	33	250	3,046	43,887	43,257	629	+2,834	15,691

[1] Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income.

[2] Includes costs of peer review organizations beginning with the implementation of the prospective payment system on October 1, 1983.

[3] Includes costs of experiments and demonstration projects.

[4] No transfer was made in 1976 because of the change in transfer dates from December to March. The 1977 transfer was for benefits and administrative expenses during the 15–month period beginning July 1976 and ending September 1977.

[5] No transfer was made in 1977 because of the change in transfer dates from August to June. The 1978 transfer was for contributions during the 5–quarter period covering the transition quarter and fiscal year 1977.

[6] Includes $2 million in reimbursement from general revenues for costs arising from the granting of deemed wage credits to persons of Japanese ancestry who were interned during World War II.

[7] Includes the lump sum general revenue transfer of $3,456 million provided for by section 151 of Public Law 98–21.

SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund: *1987 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.* Washington. U.S. Government Printing Office, Mar. 31, 1987.

Table 3.23

Operations of the Medicare supplementary medical insurance trust fund: Calendar years 1966–84

Year	Income				Disbursements			Trust fund	
	Total income	Premiums from participants	Government contributions[1]	Interest on investments and other income[2]	Total disbursements	Benefit payments	Administrative expenses	Net change	Year–end balance
	Amount in millions								
1966	$324	$322	$0	$2	$203	$128	$75	$+121	$122
1967	1,597	640	933	24	1,307	1,197	110	+290	412
1968	1,711	832	858	21	1,702	1,518	184	+9	421
1969	1,839	914	907	18	2,061	1,865	196	−222	199
1970	2,201	1,096	1,093	12	2,212	1,975	237	−11	188
1971	2,639	1,302	1,313	24	2,377	2,117	260	+262	450
1972	2,808	1,382	1,389	37	2,614	2,325	289	+194	643
1973	3,312	1,550	1,705	57	2,844	2,526	318	+468	1,111
1974	4,124	1,804	2,225	95	3,728	3,318	410	+396	1,506
1975	4,673	1,918	2,648	107	4,735	4,273	462	−62	1,444
1976	5,977	2,060	3,810	107	5,622	5,080	542	+355	1,799
1977	7,805	2,247	5,386	172	6,505	6,038	467	+1,300	3,099
1978	9,056	2,470	6,287	299	7,755	7,252	503	+1,301	4,400
1979	9,768	2,719	6,645	404	9,265	8,708	557	+503	4,902
1980	10,874	3,011	7,455	408	11,245	10,635	610	−371	4,530
1981	15,374	[3]3,722	[3]11,291	361	14,028	13,113	915	+1,346	5,877
1982	16,580	[3]3,697	[3]12,284	599	16,227	15,455	772	+353	6,230
1983	19,824	4,236	14,861	727	18,984	18,106	878	+840	7,070
1984	23,180	5,167	17,054	959	20,552	19,661	891	+2,628	9,698

[1] The payments shown as being from the general fund of the U.S. Treasury include certain interest–adjustment items.
[2] Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income.
[3] Section 708 of title VII of the Social Security Act modified the provisions for the delivery of social security benefit checks when the regularly designated delivery day falls on a Saturday, Sunday, or legal public holiday. Delivery of benefit checks normally due January 1, 1982, occurred on December 31, 1981. Consequently, the supplementary medical insurance (SMI) premiums withheld from the checks ($264 million) and the general revenue matching contributions ($883 million) were added to the SMI trust fund on December 31, 1981. These amounts are excluded from the premium income and general revenue income for calendar year 1982.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1987 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U.S. Government Printing Office, Mar. 31, 1987.

cash benefits. The 1983 Amendments to the Social Security Act changed the premium adjustment period from a 12–month period ending June 1983 to one ending December 1983. Therefore, premium adjustments are now made for a calendar year. The Part B premium was set at 25 percent of the expected average cost for aged enrollees for January 1984 through December 1985. DEFRA of 1984 extended this provision through 1987, and OBRA of 1985 further extended it through 1988.

Since the 1972 Amendments to the Social Security Act, the major source of income for the SMI trust fund has been Federal Government contributions, which made up 74 percent of total income in 1984. Enrollees' premiums made up 22 percent, and the remainder was interest on investments.

Administration

HI intermediaries

Under HI, groups or associations of providers may nominate a national, State, or other public or private agency or organization to be their intermediary. Under an agreement with the Secretary of DHHS, the intermediary determines reasonable costs for covered items and services, makes payment, and guards against unnecessary use of covered services. Under the agreement, the intermediary may also furnish consultative services to assist providers in establishing and maintaining the fiscal records needed to qualify as providers of service, serve as a center for communicating with providers, or audit provider records. HI intermediaries make payments for outpatient hospital services and home health services covered by SMI. In Table 3.24, workload and cost data for HI intermediaries are summarized for the period 1975–84.

Reasonable costs of services are determined by regulations of the Secretary of DHHS. Charges for covered services generally are submitted by the provider, who is reimbursed for reasonable costs of covered services less the deductible and coinsurance amounts. The beneficiary pays these amounts and also pays for noncovered services.

The provider's intermediary reviews claims for payment and pays the provider. Payments for claims are made on the basis of interim rates established by both provider and intermediary. Final settlement for each provider's operating year is based on the provider's cost report and is subject to an independent audit.

Medicare's retrospective cost–based system continues to apply to SNF's and HHA's but not to most hospitals. Under the prospective payment system (PPS), which began October 1983, most hospitals providing inpatient services to Medicare enrollees are no longer paid on a reasonable–cost basis. Under PPS, the intermediary assigns the appropriate diagnosis–related group code to each patient bill record and then pays the hospital a predetermined fixed rate for each discharge according to the DRG. In general, PPS payments for a given case are considered full payment except for deductible and coinsurance amounts.

Table 3.24

Medicare hospital insurance intermediary workload and cost data: Fiscal years 1975–84

Year	Bills processed		Administrative cost				Bill processing cost			
	Number in thousands	Index	Amount in millions	Index	Amount per bill	Index	Amount in millions	Index	Amount per bill	Index
1975	25,723.4	100.0	$151.8	100.0	$5.90	100.0	—	—	—	—
1976	25,898.7	100.7	164.8	108.6	5.70	96.6	—	—	—	—
1977	32,119.0	124.9	182.3	120.1	5.68	96.3	—	—	—	—
1978	34,862.4	135.5	191.3	126.0	5.49	93.1	—	—	—	—
1979	36,410.1	141.5	201.5	132.7	5.54	93.9	—	—	—	—
1980	39,789.3	154.7	216.0	142.3	5.43	92.0	—	—	—	—
1981	42,539.8	165.4	234.6	154.5	5.52	93.6	—	—	—	—
1982	45,551.7	177.1	231.9	152.8	5.09	86.3	—	—	—	—
1983	48,688.9	189.3	261.8	172.5	5.38	91.2	$104.6	100.0	$2.15	100.0
1984	50,216.0	195.2	295.7	194.8	5.89	99.8	111.7	106.8	2.22	103.3

SOURCE: Health Care Financing Administration, Bureau of Program Operations, Office of Program Administration: Data from the Division of Contractor Financial Management.

Table 3.25

Medicare supplementary medical insurance carrier workload and cost data: Fiscal years 1975–84

Year	Claims processed		Administrative cost				Claims processing cost			
	Number in thousands	Index	Amount in millions	Index	Amount per claim	Index	Amount in millions	Index	Amount per claim	Index
1975	80,613.7	100.0	$258.7	100.0	$3.21	100.0	—	—	—	—
1976	92,399.5	114.6	290.2	112.2	3.14	97.8	—	—	—	—
1977	108,126.3	134.1	322.6	124.7	2.98	92.8	—	—	—	—
1978	120,439.7	149.4	344.6	133.2	2.86	89.1	—	—	—	—
1979	133,494.9	165.6	375.3	145.0	2.81	87.5	—	—	—	—
1980	152,312.6	188.9	398.0	153.8	2.61	81.3	—	—	—	—
1981	169,541.7	210.3	450.5	174.1	2.66	82.9	—	—	—	—
1982	185,769.6	217.0	458.8	169.7	2.47	78.2	—	—	—	—
1983	204,048.8	253.1	485.8	187.8	2.38	74.1	$402.7	100.0	$1.97	100.0
1984	224,676.9	278.7	515.8	199.4	2.30	71.7	434.8	108.0	1.94	98.5

SOURCE: Health Care Financing Administration, Bureau of Program Operations, Office of Program Administration: Data from the Division of Contractor Financial Management.

SMI carriers

The Secretary of DHHS contracts with carriers to perform certain administrative duties under SMI. Carriers compute reasonable charges, make payments, determine whether claims are for covered services, and deny claims for noncovered services and unnecessary use of services. Workload and cost data for SMI carriers are presented in Table 3.25.

Claims for SMI benefits may be submitted to the carrier by the patient or by the provider. Patients who submit claims (itemized bills) directly to the carrier receive direct payment for covered services but remain responsible for the physician's (or supplier's) bill.

A physician or other supplier of services may accept assignment, accepting the reasonable charge as determined by the carrier as the total charge. The physician (or supplier) submits the bill, and the carrier reimburses 80 percent of the reasonable charge less the deductible amount. The patient is then responsible for the remaining 20 percent of the allowed charge and for any deductible.

Group health plans

The Tax Equity and Fiscal Responsibility Act of 1982 allowed HCFA to contract with health maintenance organizations (HMO's) and competitive medical plans (CMP's) on a prospective capitation payment basis for the provision of health care services to Medicare beneficiaries. Regulations to implement TEFRA were published in January 1985. HCFA signed the first such "risk" contract in April 1985. As of November 1986, there were 137 risk plans with 781,400 enrollees (Table 3.26). A year later, the comparable figures were 146 plans and 990,300 enrollees, a jump of 27 percent in enrollment. Most of the increase occurred in plans with enrollment of 50,000 members or more.

TEFRA made three major changes in the previous HMO legislation. First, it provided for a payment mechanism by which HCFA would pay contracting plans 95 percent of the adjusted average per capita cost (AAPCC) for each enrolled beneficiary. The AAPCC is HCFA's actuarial estimate of the amount that would be paid for Medicare-covered services if beneficiaries were not enrolled in HMO's. The AAPCC payment rates are adjusted for demographic factors such as age and sex and are published each September for use in the following calendar year.

Second, TEFRA legislated the "lock-in" provision. This means that beneficiaries agree to go through or to the HMO for all health care services. If enrollees do not obtain authorization for care from the HMO or CMP

Table 3.26

Number of Medicare risk plans and number of Medicare enrollees, by size of plan: November 1986–87

Size of Medicare enrollment in risk plan	Number of plans		Medicare enrollees		
	1986	1987	1986	1987	Percent change
All plans	137	146	781,378	990,299	26.7
0–99	14	5	399	283	–29.1
100–499	13	17	3,716	4,684	26.0
500–999	13	14	9,562	9,938	3.9
1,000–4,999	59	63	148,889	166,945	12.1
5,000–9,999	20	24	133,918	169,836	26.8
10,000–19,999	13	15	181,387	213,557	17.7
20,000–49,999	4	4	176,452	115,558	–34.5
50,000 or more	1	4	127,055	309,498	143.6

NOTE: Medicare risk plans comprise health maintenance organizations and competitive medical plans.

SOURCE: Health Care Financing Administration, Office of Prepaid Health Care: Data from the Division of Contract Administration.

(other than for emergency or urgently needed services), neither the HMO or CMP nor HCFA will pay for these services.

Third, TEFRA allowed HCFA to contract with CMP's as well as federally qualified HMO's. CMP's are determined eligible by HCFA through a process similar to that used for Federal HMO qualification. However, some organizations may find it easier to qualify as a CMP. For example, CMP's may be a separate line of business of an organization, such as an insurance company, whereas HMO's must be a separate legal entity.

There are advantages to beneficiaries, Government, and industry as a result of the TEFRA risk contract program. Beneficiaries who enroll usually receive benefits not covered under regular Medicare; pay the Medicare premium and, generally, a fixed monthly payment; and do not submit Medicare claims forms. The Government is able to provide access to health care that is rendered in an effective and efficient manner while promoting competition and the private health plan option. The industry receives fixed monthly payments, can contract with HCFA in the same way as their commercial clients, and can offer services to the virtually untapped market of Medicare beneficiaries.

Medicare statistical system

The Medicare statistical system provides data for analyzing and evaluating the program's effectiveness. The system consists of four major computer files: the health insurance master, the provider of service, the HI claims, and the SMI payment records files.

The health insurance master file contains records for each aged and disabled enrollee and includes data on the enrollee's type of entitlement, deductible status, benefit period status, and benefits used. This file provides population data for the program and is the base used in computing a variety of user rates by age, sex, race, and residence.

The provider of service file contains information on hospitals, home health agencies, skilled nursing facilities, independent clinical laboratories, suppliers of portable X-ray or outpatient physical therapy services, and all other providers and suppliers of services that participate in Medicare. This file consists of data from two types of forms, the provider application for participation form and the certification-and-transmittal form. For hospitals, it includes data on the number of beds, type of ownership, and other characteristics. Provider data are updated regularly.

The HI claims file contains information on beneficiaries' entitlement and the extent to which enrollees have used covered benefits. When an enrollee uses a participating medical facility (for example, a hospital or skilled nursing facility), admission and billing forms are forwarded to HCFA's Central Office. All benefit period information needed by intermediaries is recorded in this office. Information is included on stays in certain nonparticipating institutions and days of care not covered or reimbursable under the program. The admission and billing forms contain both a Medicare enrollee identification number and a provider number. A computer tape record of these data, when matched with enrollee entitlement and provider tapes, forms a statistical research tape that contains enrollee, provider, use-of-service, and cost data for each enrollee. As part of the data sampling process, information on diagnoses and surgical procedures (the basis of the hospital data in this report) is obtained for a 20-percent sample of hospitalized enrollees.

The HCFA central SMI payment records file is used to inform carriers whether or not enrollees have met the deductible. It also provides information on amounts paid by carriers for physicians' services and for other SMI-covered services and supplies. A bill summary file is derived from a sample of the SMI payment records file for statistical research.

To better meet Medicare's data needs on physicians' reimbursement, the following four files are generated from all SMI carrier service data.

- A procedure file contains complete counts of all physician medical procedures, medical supplies, amounts charged, and amounts paid. This file provides complete information on Medicare physician and supplier services.

- A prevailing charge file provides prevailing charge information for each service in the procedure file. This allows HCFA to study and forecast payment levels more accurately.
- A provider file contains data from submitted claims on all services rendered by a sample of physicians and suppliers. This allows study of the effect of program changes on physicians' service practices and permits longitudinal analysis of these practices.
- A beneficiary file provides a complete record, from submitted claims, of services received by a sample of beneficiaries. This permits linkage of information on beneficiary use of physicians' and suppliers' services to already existing files containing data on the use of HI services.

These four files supplement data currently available and have been prepared annually beginning with 1983. These files are used by numerous bureaus and offices in HCFA. In the Office of Research and Demonstrations, for example, they are used to provide data and analysis on specific procedures, physician practices, and patient episodes.

The Medicare statistical system enables HCFA to prepare a wide variety of research studies on the use of and reimbursement for Medicare services. Data from the system provide information about enrollee use of benefits for a point in time or over an extended period. Statistical reports are produced on enrollment, characteristics of participating providers, reimbursements, and services used.

Medicare also has implemented the Continuous Medicare History Sample (CMHS) beginning with 1974 data. CMHS provides longitudinal data on Medicare program use by a sample of enrollees. The CMHS files consist of data from all of the Medicare user files for a number of years. Selected data from the enrollment and user files have been combined into one record for each sample person to acquire specific person data.

CMHS is a 5-percent probability sample of Medicare health insurance claim numbers. New enrollees whose claim numbers place them in CMHS are added to the sample, and the records for enrollees whose Medicare coverage ends are retained in the file. The ability to link different data files over a period of years is a key feature of CMHS and the Medicare statistical system. It permits detailed analysis of specific groups of enrollees over time.

4. Medicaid: Description and data

Detailed information on the Medicaid program, including eligibility criteria, recipient characteristics, benefit coverage, service use, expenditures, financing, and administration, are presented in this chapter.[6] Explanations of program requirements are based on regulations contained in title 42 of the U.S. *Code of Federal Regulations* (CFR), parts 430–456.

First, information is given on Federal requirements and State options in defining the eligibility of the categorically and medically needy. Data are presented on the distribution of recipients by State, eligibility category, age, and sex. Medicaid benefits offered by each State, including optional services, benefit limitations, and cost-sharing requirements, are described. Data on the use of Medicaid-covered services are also presented, including data for each State on the distribution of recipients, number of recipients, and total volume of services by type of service.

The next focus is Medicaid expenditures. The distribution of State expenditures is shown by eligibility category, age, and sex of recipients and by type of service. Comparisons of average expenditures per recipient by State are also presented. A description of Medicaid financing, including information on matching rates for Federal financial participation, follows.

Various topics concerning Medicaid administration, including provider reimbursement methods, expenditures for administrative training, numbers of certified providers, administrative responsibility for eligibility determination, and adoption of management information systems, are discussed. This discussion is followed by a description of the Medicaid data system.

Eligibility

Medicaid is a major component of the current public assistance system, and its eligibility provisions are among the most complex of all assistance programs. At a minimum, States must cover all persons who receive cash payments from the Aid to Families with Dependent Children (AFDC) program and almost all persons covered by the Supplemental Security Income (SSI) program. These persons are called the categorically needy. States have the option of extending Medicaid coverage to the medically needy and to specified groups of people known as the optionally categorically needy. The medically needy are categorically related individuals who are ineligible for cash assistance on the basis of income and financial resources but whose income and resources are considered insufficient to meet their medical needs. In this section, the standards States use to determine who is eligible for Medicaid are described.

[6] The numbers presented in the tables may differ from those in previous publications, including those found in former editions of the *Medicare and Medicaid Data Book*. These differences were caused mainly by late reports received by the Health Care Financing Administration and resulting adjustments.

Categorically needy

As shown in Figure 4.1, the categorically needy include AFDC and SSI cash assistance recipients and may also include optional groups related to each cash assistance category. A discussion of the AFDC and SSI categories follows.

Aid to Families with Dependent Children

A State is required to cover all persons receiving cash assistance through its AFDC program. AFDC payments are made to families with children in which one parent is absent or incapacitated. At State option, AFDC payments may be made to two-parent families in which the principal breadwinner is unemployed. Additional AFDC options are for coverage of pregnant women without other children in their care and children age 18 who are regularly attending school. If the State extends AFDC coverage to these groups, it must extend Medicaid coverage as well. The States that offer coverage to these groups are shown in Table 4.1.

States are also required to provide Medicaid to certain other groups on the same basis as AFDC recipients even though they do not receive AFDC. These groups include children receiving assistance from programs funded under title IV-E of the Social Security Act to support foster care and adoptions; families terminated from AFDC because of their income from employment or the receipt of child support from an absent parent; families who do not receive AFDC because the amount they qualify for is less than the minimum amount AFDC will pay; all pregnant women and all children under the age of 7 (8 at State option) born after October 1, 1983, whose family income and resources are at or below AFDC levels but who do not meet other nonfinancial AFDC requirements.

States also have options to cover certain other "AFDC-related" groups. The States that cover the following optional categorically needy groups are shown in Table 4.1.

- Individuals under age 21 (20, 19, or 18 at State option) who meet AFDC income and resource limits but do not qualify for AFDC because they do not meet the AFDC definition of a dependent child. Usually this means that they live with both parents and the principal breadwinner is employed. States may cover all such children or limit coverage to categories of children who live with neither parent, such as those in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities.
- Individuals who are eligible for but not receiving cash assistance.
- Individuals who would be eligible for AFDC cash assistance if they were not institutionalized.

Figure 4.1
Medicaid eligibility of the categorically needy: March 31, 1984

Eligibility criteria for the categorically needy

- Aged, blind, disabled, or member of family unit deprived of support of parent.
- Income standard.
- Resource standard.

AFDC populations for which coverage is:

Mandatory

- Individuals receiving AFDC payments (42 CFR 435.110)
- Families terminated from AFDC because of increased earnings or hours of employment (42 CFR 435.112)
- Individuals ineligible for AFDC because of requirements that do not apply under title XIX of the Social Security Act (42 CFR 435.113)
- Individuals who would be eligible for AFDC except for increased OASDI income under Public Law 92-336 of July 1, 1972 (42 CFR 435.114)
- Deemed recipients of AFDC (42 CFR 435.115)
- Children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Social Security Act (42 CFR 435.118)

Optional

- Individuals eligible for but not receiving cash assistance (42 CFR 435.210)
- Individuals who would be eligible for cash assistance except for institutional status (42 CFR 435.211)
- Individuals who would be eligible for AFDC if child care costs were paid from earnings (42 CFR 435.220)
- Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children (42 CFR 435.222)
- Individuals who would be eligible if coverage under State's AFDC plan were as broad as allowed under title IV-A of the Social Security Act (42 CFR 435.223)

SSI populations for which coverage is:

Mandatory

- Individuals receiving SSI payments (42 CFR 435.120)
- Individuals in States using more restrictive requirements for Medicaid than SSI (42 CFR 435.121)
- Individuals ineligible because of requirements that do not apply under Medicaid (42 CFR 435.122)
- Individuals receiving mandatory State supplements (42 CFR 435.130)
- Individuals who in Dec. 1973 were eligible for Medicaid as an essential spouse and who have continued to live with and be essential to the well-being of a recipient of cash assistance (42 CFR 435.131)
- Institutionalized individuals eligible in Dec. 1973 (42 CFR 435.132)
- Blind and disabled individuals eligible in Dec. 1973 (42 CFR 435.133)
- Individuals who would be eligible except for increased OASDI income under Public Law 92-336 of July 1, 1972 (42 CFR 435.134)
- Individuals who: (a) become ineligible for cash assistance as a result of OASDI cost-of-living increases received after Apr. 1977; (b) would still be eligible for SSI or SSP if that increase were deducted from income (42 CFR 435.135)

Optional

- Individuals eligible for but not receiving cash assistance (42 CFR 435.210)
- Individuals who would be eligible for cash assistance except for institutional status (42 CFR 435.211)
- Individuals who would be eligible for AFDC if child care costs were paid from earnings (42 CFR 435.220)
- Individuals receiving only optional State supplements (42 CFR 435.230)
- Individuals in institutions who are eligible under a special income level (42 CFR 435.231)
- Individuals receiving home and community-based services who are eligible under a special income level (42 CFR 435.232)
- Certain disabled children age 18 or under who live at home and would be eligible if in a medical institution (1902(e)(3) of the Social Security Act, Public Law 97-248, section 134)

NOTES: AFDC is Aid to Families with Dependent Children; SSI is supplemental security income; OASDI is Old Age, Survivors, and Disability Insurance; SSP is State Supplemental Payments; CFR is *Code of Federal Regulations*.

SOURCE: *Code of Federal Regulations*: Public Health, Title 42, Chapter IV. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office.

Table 4.1

Medicaid coverage under Aid to Families with Dependent Children, by jurisdiction: March 1986

Medicaid jurisdiction	Mandatory coverage			Optional coverage				
						Persons who would be eligible		
	Families with unemployed parents	Pregnant women with no eligible children	Children age 18 regularly attending school	Financially eligible persons under age 21	Persons eligible for but not receiving cash	Except for institutional status	If State plan were as broad as Social Security Act allows	If child care costs were paid from earnings
Alabama	N	N	N	Y	N	Y	N	N
Alaska	N	Y	N	Y	Y	Y	N	N
Arkansas	N	N	N	Y	N	Y	N	N
California	Y	Y	Y	N	N	N	N	N
Colorado	N	Y	Y	Y	Y	Y	N	Y
Connecticut	Y	Y	Y	N	Y	Y	N	N
Delaware	Y	Y	N	Y	N	Y	N	N
District of Columbia	Y	Y	Y	N	Y	Y	N	Y
Florida	N	Y	N	Y	N	Y	Y	N
Georgia	N	N	N	N	N	Y	N	N
Hawaii	Y	Y	Y	Y	Y	Y	Y	Y
Idaho	N	Y	Y	Y	Y	Y	Y	N
Illinois	Y	Y	Y	Y	N	N	N	N
Indiana	N	N	N	Y	N	N	N	N
Iowa	Y	Y	N	Y	Y	Y	N	N
Kansas	Y	Y	Y	Y	N	N	N	N
Kentucky	N	N	Y	Y	N	N	Y	N
Louisiana	N	Y	Y	Y	N	Y	N	N
Maine	Y	N	N	N	Y	Y	N	N
Maryland	Y	Y	Y	N	Y	Y	N	N
Massachusetts	Y	Y	Y	N	Y	Y	N	N
Michigan	Y	Y	Y	N	N	N	N	N
Minnesota	Y	Y	Y	N	Y	Y	Y	Y
Mississippi	N	N	N	N	N	Y	N	N
Missouri	Y	N	Y	Y	N	N	N	N
Montana	Y	Y	Y	Y	Y	Y	N	Y
Nebraska	Y	Y	Y	N	N	N	N	N
Nevada	N	Y	Y	Y	N	Y	N	N
New Hampshire	N	N	Y	Y	Y	Y	N	N
New Jersey	Y	N	Y	N	Y	Y	Y	N
New Mexico	N	Y	Y	Y	N	Y	N	N
New York	Y	Y	Y	N	Y	Y	Y	Y
North Carolina	N	Y	Y	Y	Y	N	N	N
North Dakota	N	Y	Y	N	N	N	N	N
Ohio	Y	Y	Y	Y	N	Y	N	Y
Oklahoma	N	N	Y	N	Y	Y	N	Y
Oregon	Y	Y	Y	Y	Y	Y	N	N
Pennsylvania	Y	N	Y	Y	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y	Y	Y	Y	Y
South Carolina	Y	Y	Y	Y	N	Y	N	N
South Dakota	N	N	Y	Y	N	Y	N	N
Tennessee	N	Y	Y	Y	N	Y	N	N
Texas	N	N	Y	Y	N	Y	N	N
Utah	N	Y	Y	Y	Y	Y	N	Y
Vermont	Y	Y	Y	Y	Y	Y	Y	Y
Virginia	N	N	Y	Y	Y	Y	N	N
Washington	Y	Y	Y	Y	Y	Y	N	N
West Virginia	Y	N	N	Y	Y	N	N	N
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y
Wyoming	N	Y	Y	Y	N	Y	N	N

NOTE: Y is yes; N is no.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.2

Annual need and payment standards for Aid to Families with Dependent Children and annual income levels for the medically needy, by family size and jurisdiction: March 1986

Medicaid jurisdiction	AFDC[1] standard				Income level protected for maintenance for medically needy	
	2-person family		4-person family			
	Need	Payment	Need	Payment	2-person family	4-person family
Alabama	$3,456	$1,056	$5,760	$1,764	[3]	[3]
Alaska	7,404	7,404	9,300	9,300	[3]	[3]
Arkansas	2,316	1,896	3,276	2,688	$2,604	$3,600
California	5,688	5,688	8,376	8,376	7,608	11,208
Colorado	3,972	3,264	5,268	4,332	[3]	[3]
Connecticut[2]	5,508	5,508	7,968	7,968	6,696	9,600
Delaware	2,640	2,640	4,188	4,188	[3]	[3]
District of Columbia	6,168	3,084	9,576	4,788	—	—
Florida	3,564	2,328	5,616	3,576	[3]	[3]
Georgia	3,672	2,244	5,184	3,168	3,000	4,296
Hawaii	5,160	5,160	7,212	7,212	5,160	7,212
Idaho	5,352	2,940	6,648	3,648	[3]	[3]
Illinois[2]	5,964	3,000	9,216	4,620	3,996	6,204
Indiana	2,964	2,964	4,356	4,356	[3]	[3]
Iowa	5,052	3,864	6,936	5,316	5,196	7,092
Kansas[2]	3,936	3,936	5,400	5,400	5,304	5,520
Kentucky	1,944	1,944	2,820	2,820	2,604	3,804
Louisiana[2]	5,172	1,656	8,856	2,808	2,304	3,804
Maine	4,776	3,468	8,088	5,868	4,692	7,896
Maryland	4,248	3,072	6,552	4,740	4,104	5,100
Massachusetts	4,380	4,296	6,180	6,060	5,796	6,108
Michigan[2]	5,664	4,716	8,352	6,960	6,300	6,960
Minnesota	5,208	5,208	7,392	7,392	5,208	7,392
Mississippi	2,928	2,928	3,924	3,924	[3]	[3]
Missouri	3,000	2,508	4,380	3,660	[3]	[3]
Montana[2]	4,092	3,384	6,168	5,112	4,596	5,112
Nebraska	3,360	3,360	5,040	5,040	4,500	6,300
Nevada	2,748	2,748	4,092	4,092	[3]	[3]
New Hampshire	3,948	3,948	5,304	5,304	5,292	5,700
New Jersey	3,684	3,684	5,580	5,580	[3]	[3]
New Mexico	1,464	1,464	2,496	2,496	[3]	[3]
New York[2]	6,048	6,048	8,484	8,484	7,200	7,308
North Carolina	5,136	2,568	6,456	3,228	3,500	4,400
North Dakota	3,612	3,612	5,448	5,448	4,800	6,360
Ohio	6,432	2,976	9,708	4,488	[3]	[3]
Oklahoma	4,368	2,880	6,996	4,608	3,900	6,204
Oregon	4,056	4,056	5,784	5,784	5,408	7,712
Pennsylvania[2]	5,772	3,780	8,988	5,880	5,100	6,500
Rhode Island[2]	4,770	4,770	6,720	6,720	6,400	9,000
South Carolina	3,528	1,896	5,328	2,868	[3]	[3]
South Dakota[2]	3,432	3,432	4,452	4,452	[3]	[3]
Tennessee	3,120	1,404	4,956	2,232	1,896	3,000
Texas	5,916	1,896	8,292	2,652	2,532	3,612
Utah	6,672	3,612	9,708	5,268	4,812	7,020
Vermont[2]	8,376	5,532	11,316	7,476	7,272	7,476
Virginia[2]	3,924	3,528	5,484	4,920	10,800	13,200
Washington	7,536	4,764	10,968	6,936	6,312	6,936
West Virginia[2]	4,812	2,412	7,476	3,744	2,700	3,300
Wisconsin[2]	7,692	6,540	9,168	7,788	7,500	9,168
Wyoming	3,840	3,840	4,680	4,680	[3]	[3]

[1] Aid to Families with Dependent Children.
[2] No uniform standards throughout State. The highest standards in the range are shown.
[3] Medically needy not included in Medicaid program.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

- Individuals who would be eligible for AFDC payments if the State AFDC program were as broad as title IV-A of the Social Security Act allows.
- Individuals who would be eligible for AFDC payments if child care costs were paid from earnings.

States also have the option to cover the following AFDC-related groups: pregnant women whose family income is higher than AFDC levels but not higher than 185 percent of Federal poverty guidelines; children under 1 year of age whose family income does not exceed 185 percent of the poverty level; children born on or after October 1, 1983, whose family income is higher than AFDC levels but not higher than 100 percent of the poverty level (covered until age 8); families that would receive AFDC if their State had elected to cover that type of family in its AFDC program; children with special medical or rehabilitative needs adopted under a State program for facilitating adoptions.

Income standards for cash assistance and Medicaid eligibility are set by the States. Data for 1986 on the annual AFDC need and payment standards used by States to determine Medicaid eligibility for AFDC recipients and, for States with such a program, the medically needy are shown in Table 4.2. Eligibility standards for the medically needy are discussed later. Data are shown for two-person and four-person families. Data for other family sizes are available from State public assistance plans.

The need standard is the amount of money a State determines essential to meet a minimal standard of living in that State for a specified family size. In general, the standard provides for basic consumption items, such as food, clothing, shelter, fuel and utilities, personal care items, household items, and, in certain cases, special or recurrent needs. Some States vary the need standard to reflect differences in actual costs within the State, others vary it by season, and one varies it according to the age of the child.

In addition to the need standard, States set the standard of payment for AFDC families. Payment standards vary widely, from a high of $9,300 in Alaska to a low of $1,764 in Alabama for four-person families. (Program data for the four territories of Guam, the Northern Marianas, Puerto Rico, and the Virgin Islands are not included in Table 4.2.) For most States, the payment standard is the maximum amount of cash assistance paid to a family with no countable income. Approximately 60 percent of the States set a payment standard that is lower than the need standard. It should be noted, however, that these States may provide a substantially higher level of assistance than States meeting full need under a relatively low standard.

Supplemental Security Income

Just as AFDC is the basic reference point for Medicaid eligibility for families and children, SSI is the basic reference point for Medicaid eligibility for the aged, blind, and disabled. However, States are required to provide Medicaid to all AFDC recipients but not to all SSI recipients.

SSI was implemented on January 1, 1974. Before SSI was implemented, States were responsible for cash assistance for the aged, blind, and disabled, with the same kind of authority to set eligibility rules as they had for AFDC. SSI largely replaced these State programs with a nationally uniform Federal program. Because SSI was more generous than some State programs that it replaced and more restrictive than others, a number of special provisions affecting Medicaid were enacted to protect the Medicaid eligibility of persons who would lose eligibility for cash assistance under SSI and to protect the financial interests of States against a substantial increase in caseload size.

Each State was permitted to choose between extending Medicaid to all recipients of SSI or, under the "209(b)" option, electing to use some or all of its pre-SSI eligibility criteria and provide Medicaid only to aged, blind, or disabled persons meeting those more restrictive criteria. To protect the interests of recipients, 209(b) States are required to adopt a "spend-down" for Medicaid for any eligibility category for which more restrictive Medicaid criteria are applied. The spend-down requirement was designed to address situations in which 209(b) States set more restrictive income thresholds for eligibility than SSI; however, it applies even to States that use SSI income levels but are more restrictive on other criteria, such as lower asset levels or a more limited definition of blindness.

Individuals who would otherwise have lost Medicaid in the transition from State cash programs to SSI were "grandfathered" into Medicaid if they belonged to the following groups.

- Blind and disabled persons who received Aid to the Blind or Aid to the Permanently and Totally Disabled in December 1973 and whose blindness or disability was not severe enough to meet SSI criteria.
- Essential spouses (spouses whose help is considered essential to the well-being of SSI recipients) who were excluded from SSI because they were neither disabled nor elderly.
- Certain medically needy persons in institutions.
- Recipients of mandatory State supplementation—payments that States are required to make to persons who have too much income to qualify for SSI but who qualified for cash benefits in December 1973 (before SSI) because their State provided higher cash benefit levels that SSI.

In recent years, Congress has passed legislation requiring that States continue Medicaid coverage of persons who would otherwise lose it because of congressional acts to improve benefits in such programs as social security. Special eligibility provisions have been enacted to extend Medicaid coverage to the following groups.

- Former recipients of SSI (or AFDC) whose incomes would be within SSI limits if they had not received a social security cost-of-living adjustment.

Table 4.3

Medicaid coverage under Supplemental Security Income, by jurisdiction: March 1986

Medicaid jurisdiction	Mandatory coverage		Optional coverage				
	All Supplemental Security Income recipients	More restricted eligibility	State supplement recipients			Persons eligible for but not receiving aid	Persons eligible except for institutional status
			Aged	Blind	Disabled		
Alabama	Y	N	Y	Y	Y	N	Y
Alaska	Y	N	Y	Y	Y	Y	Y
Arkansas	Y	N	N	N	N	N	Y
California	Y	N	Y	Y	Y	N	N
Colorado	Y	N	Y	N	N	Y	Y
Connecticut	N	Y	Y	Y	Y	Y	Y
Delaware	Y	N	N	N	N	N	Y
District of Columbia	Y	N	N	N	N	Y	Y
Florida	Y	N	N	N	N	N	Y
Georgia	Y	N	N	N	N	N	Y
Hawaii	N	Y	Y	Y	Y	Y	Y
Idaho	Y	N	Y	Y	Y	Y	Y
Illinois	N	Y	Y	Y	Y	N	N
Indiana	N	Y	N	N	N	N	N
Iowa	Y	N	N	Y	N	Y	Y
Kansas	Y	N	N	N	N	N	N
Kentucky	Y	N	N	N	N	N	N
Louisiana	Y	N	N	N	N	N	Y
Maine	Y	N	Y	Y	Y	Y	Y
Maryland	Y	N	N	N	N	Y	Y
Massachusetts	Y	N	Y	Y	Y	Y	Y
Michigan	Y	N	Y	Y	Y	N	N
Minnesota	N	Y	Y	Y	Y	Y	Y
Mississippi	Y	N	N	N	N	N	Y
Missouri	N	Y	N	Y	N	N	N
Montana	Y	N	N	N	N	Y	Y
Nebraska	N	Y	Y	Y	Y	N	N
Nevada	Y	N	N	N	N	N	Y
New Hampshire	N	Y	Y	Y	Y	Y	Y
New Jersey	Y	N	Y	Y	Y	Y	Y
New Mexico	Y	N	N	N	N	N	Y
New York	Y	N	Y	Y	Y	Y	Y
North Carolina	N	Y	Y	Y	Y	Y	N
North Dakota	N	Y	N	N	N	N	N
Ohio	N	Y	N	N	N	N	Y
Oklahoma	N	Y	N	N	N	Y	Y
Oregon	Y	N	Y	Y	Y	Y	Y
Pennsylvania	Y	N	Y	Y	Y	Y	Y
Rhode Island	Y	N	Y	Y	Y	Y	Y
South Carolina	Y	N	N	N	N	N	Y
South Dakota	Y	N	N	N	N	N	Y
Tennessee	Y	N	N	N	N	N	Y
Texas	Y	N	N	N	N	N	Y
Utah	N	Y	N	N	N	Y	Y
Vermont	Y	N	Y	Y	Y	Y	Y
Virginia	N	Y	N	N	N	Y	Y
Washington	Y	N	Y	Y	Y	Y	Y
West Virginia	Y	N	N	N	N	Y	N
Wisconsin	Y	N	Y	Y	Y	Y	Y
Wyoming	Y	N	N	N	N	N	Y

NOTE: Y is yes; N is no.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Figure 4.2
Medicaid eligibility coverage of the medically needy: March 31, 1984

Eligibility criteria for the medically needy

- Member of categorically related group.
- Income standard met or income more than allowed but medical expenses incurred are at least equal to the difference between income and the applicable income standard.
- Resource standard.

Populations for which coverage is:

Mandatory	Optional
• All pregnant women during the course of their pregnancy (42 CFR 435.301(b)(1)(i))	• Caretaker relatives (42 CFR 435.310)
• All individuals or reasonable classifications of those individuals under age 21 (42 CFR 435.308)	• Aged (42 CFR 435.320)
• Blind and disabled individuals eligible in Dec. 1973 (42 CFR 435.340)	• Blind (42 CFR 435.322)
	• Disabled (42 CFR 435.324)
	• Aged, blind, and disabled in States imposing more restrictive eligibility requirements than supplemental security income (42 CFR 435.330)

NOTE: CFR is *Code of Federal Regulations*.

SOURCE: *Code of Federal Regulations*: Public Health, Title 42, Chapter IV. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office.

- Some disabled persons (widows, widowers, and certain children) who lost SSI because of increases in social security benefits.
- Disabled persons who formerly received SSI, who are employed despite their medical impairments, and whose earnings, although substantial, are less than the benefits they would receive if they did not work and relied instead on public programs for assistance in meeting their need for income, medical care, and other support.

States have the option to provide Medicaid to certain aged, blind, or disabled persons as if they were SSI recipients. In Table 4.3 are shown the States that cover the following optional groups.

- Persons who receive State supplemental payments only, not SSI. States make these payments at their option with State-only funds to provide a higher minimum income either for all aged, blind, and disabled persons in the State or for such reasonable classifications as persons in supervised group living arrangements.
- Persons eligible for but not receiving cash assistance.
- Persons eligible except for institutional status.

States also have the option to cover the following groups: persons in medical institutions whose incomes are below a State-set income threshold of not more than 300 percent of the maximum SSI benefit; persons in the community whose incomes are below a State-set threshold of not more than 300 percent of SSI and who need institutional-level care, which they are receiving instead under a home and community-based waiver under section 1915(c) of the Act; persons with incomes higher than SSI but not higher than 100 percent of Federal poverty guidelines (limited to States that also elect to cover pregnant women and children below the poverty level); severely disabled children, regardless of their parents' incomes or assets, if they need the level of care normally provided in an institution and if that care can appropriately be provided at home at less cost to Medicaid than institutional care.

Medically needy

The medically needy program is one of the most important coverage options that can be exercised under the Medicaid program. The intent of the medically needy option is to accommodate individuals who meet all criteria for categorically needy assistance with the exception of income and who are unable to afford medical bills (Figure 4.2). Since the enactment of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81), States have been permitted to offer medically needy coverage to some groups but not to others—for example, to the aged and disabled but not to parents of dependent children. However, a State providing any medically needy coverage at all must, at a minimum, cover medically needy pregnant women and

children under age 18. Medical benefits may vary by medically needy group.

Since 1969, a State's medically needy income standard has been limited to 133⅓ percent of the maximum AFDC assistance payment for a family of the same size. For Federal matching purposes, this means that the Federal Government recognizes as medically needy only those persons whose "countable" income does not exceed 133⅓ percent of the maximum payment standard set by the State. Annual income levels for the medically needy in States with such a program are shown in Table 4.2. Each State is required to employ a single statewide income standard when determining eligibility for medically needy individuals and families.

Persons with income above cash assistance levels but below medically needy levels qualify without having to spend down. However, under the medically needy spend-down provision (42 CFR 435.831), persons or families with incomes above the medically needy income standard can deduct certain incurred medical expenses for purposes of determining their countable income. Among the medical services that they are allowed to deduct are Medicare and other health insurance premiums, deductibles, or coinsurance charges; expenses incurred for medical and remedial services included in the State Medicaid plan; and expenses incurred for services not included in the State plan but recognized under State law.

State-only coverage

A State may extend Medicaid coverage to individuals not in the preceding groups only at its own expense. The Federal Government will not provide matching assistance in such cases. These groups are referred to as noncategorically medically needy, or State-only, eligibles. They include:

- Individuals who receive or are eligible for general assistance under a statewide program.
- Persons 21-65 years of age who have "sufficient" income and resources to meet daily needs, but not medical expenses, and who are ineligible for Medicaid under the adult or AFDC categories.
- Persons with incomes above the federally established maximum for medically needy groups. Persons covered fully at State expense need not meet any of the requirements for categorical eligibility. For example, a young, single male over age 21 and living alone could, at State option, receive Medicaid benefits as a State-only eligible.

Recipients

In this section, data on Medicaid recipients are presented by maintenance assistance status, eligibility category, and demographic characteristics. The percent distribution of Medicaid recipients by basis of eligibility and maintenance assistance status in fiscal year 1985 is shown in Table 4.4.

Individuals eligible for Medicaid are classified into two major groups according to their maintenance assistance status. "Cash assistance" recipients receive cash assistance for their basic necessities under public assistance programs; "medical assistance only" individuals do not. The medical assistance only group includes both the medically needy and categorically eligible persons not receiving cash assistance. Of the approximately 21.8 million Medicaid recipients in fiscal year 1985, the majority (73.2 percent) received cash assistance. Of the approximately 3.1 million Medicaid recipients 65 years of age or over, 54.3 percent received cash assistance.

Within the two maintenance assistance groups, persons receiving Medicaid services are classified by basis of eligibility. Eligibility groups include persons aged 65 or over, the blind, the disabled, dependent children under age 21, and adults in families with dependent children. Some States extend Medicaid coverage to children not in any of these categories. Such children are classified as "other title XIX recipients" and do not receive cash assistance. State-only eligibles are not included in Table 4.4.

Table 4.4

Number and percent distribution of Medicaid recipients, by maintenance assistance status and basis of eligibility: Fiscal year 1985

Basis of eligibility	Number of recipients in thousands	Maintenance assistance status		
		Total	Cash assistance	Medical assistance only
		Percent distribution		
Total	[1]21,808.3	100.0	73.2	26.8
Age 65 or over	3,061.4	100.0	54.3	45.7
Blind	80.3	100.0	88.2	11.8
Disabled	2,936.4	100.0	78.1	21.9
Dependent children under age 21	9,752.4	100.0	83.6	16.4
Adults in families with dependent children	5,517.5	100.0	78.5	21.5
Other title XIX	1,213.6	100.0	NA	100.0

[1] The sum of recipients exceeds total recipients because recipients who are eligible in more than one category are counted in each category but only once in the total.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

In Table 4.5, the number of Medicaid recipients in fiscal year 1985 is shown for each jurisdiction. Programs are ranked by percent of total recipients. The cumulative percent of national recipients and the distribution of recipients by eligibility category are also shown. Seventy percent of all recipients were in the AFDC category; 14 percent were in the group aged 65 or over. Cumulatively, six programs—California, New York, Puerto Rico, Michigan, Pennsylvania, and Illinois—accounted for 48 percent of all Medicaid recipients, and 17 programs served 76 percent of all Medicaid recipients.

The distributions of recipients for each Medicaid program by age, sex, and race or ethnic origin are shown in Table 4.6. During fiscal year 1985, 50.9 percent of all recipients were under 21 years of age and 17.1 percent were 65 years of age or over. Females accounted for 64.1 percent of total recipients.

Table 4.5

Number and percent distribution of Medicaid recipients, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1985

Medicaid jurisdiction	Number of recipients in thousands	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	AFDC[2]	Other title XIX
				Percent distribution				
All jurisdictions	21,808.3	100.0	100.0	14.0	0.4	13.5	70.0	5.6
California	3,380.7	15.5	15.5	13.5	0.7	14.6	65.4	5.8
New York	2,242.1	10.3	25.8	15.2	0.2	13.0	65.5	6.1
Puerto Rico	1,571.9	7.2	33.0	0.0	0.1	4.3	64.2	31.4
Michigan	1,133.3	5.2	38.2	8.2	0.2	12.1	86.4	5.9
Pennsylvania	1,071.0	4.9	43.1	11.3	0.1	12.3	78.4	7.0
Illinois	1,063.4	4.9	48.0	7.1	0.1	11.9	80.1	0.8
Ohio	1,045.1	4.8	52.8	9.3	0.2	10.9	87.1	0.0
Texas	761.3	3.5	56.3	28.0	0.5	14.2	57.0	0.3
New Jersey	581.4	2.7	59.0	10.9	0.2	12.3	77.4	2.5
Florida	561.9	2.6	61.6	20.0	0.5	18.7	59.8	1.0
Massachusetts	522.9	2.4	64.0	20.0	1.3	13.5	58.2	7.0
Wisconsin	473.3	2.2	66.2	15.8	0.2	13.7	86.2	2.3
Georgia	468.9	2.2	68.4	19.6	0.7	21.5	66.8	0.4
Louisiana	416.2	1.9	70.3	21.0	0.4	16.4	61.1	1.1
Kentucky	408.2	1.9	72.2	13.9	0.5	17.3	75.5	1.1
Tennessee	362.1	1.7	73.9	20.8	0.7	22.2	53.4	2.8
Minnesota	357.3	1.6	75.5	15.6	0.2	10.2	64.5	9.6
Missouri	356.0	1.6	77.1	17.9	0.4	14.7	66.0	1.0
North Carolina	343.2	1.6	78.7	18.5	0.5	13.7	66.0	1.3
Maryland	328.8	1.5	80.2	13.0	0.1	11.5	74.1	1.3
Washington	326.4	1.5	81.7	13.2	0.1	13.4	82.2	0.2
Alabama	316.2	1.4	83.1	26.8	0.6	21.7	55.1	1.2
Virginia	303.0	1.4	84.5	18.6	0.4	15.5	63.7	1.8
Mississippi	299.7	1.4	85.9	21.3	0.6	19.6	58.2	0.4
Indiana	284.0	1.3	87.2	14.6	0.4	13.9	77.1	0.0
Oklahoma	270.0	1.2	88.4	20.9	0.2	9.9	68.0	1.0
South Carolina	237.6	1.1	89.5	19.2	0.8	22.1	90.4	0.1
Connecticut	217.4	1.0	90.5	16.3	0.1	10.3	67.1	6.2
Iowa	211.9	1.0	91.5	14.0	0.4	10.2	78.1	7.5
West Virginia	211.4	1.0	92.5	11.4	0.1	13.8	74.9	0.9
Arkansas	197.3	0.9	93.4	26.1	0.7	21.8	45.4	6.0
Oregon	152.5	0.7	94.1	13.1	0.7	11.9	70.4	3.9
Colorado	147.3	0.7	94.8	23.1	0.2	18.6	81.1	0.0
Kansas	141.7	0.6	95.4	17.0	0.2	13.3	75.1	1.4
Maine	124.4	0.6	96.0	16.5	0.2	15.2	80.2	0.0
Rhode Island	100.8	0.5	96.5	20.4	0.3	18.1	60.6	0.7
District of Columbia	98.3	0.5	97.0	9.9	0.1	14.7	71.4	3.9
Nebraska	93.9	0.4	97.4	16.5	0.2	10.5	67.0	5.8
Hawaii	92.2	0.4	97.8	12.2	0.2	8.5	83.7	1.1
New Mexico	87.3	0.4	98.2	13.5	0.5	18.7	67.2	0.0
Utah	72.2	0.3	98.5	10.7	0.1	11.4	80.4	8.5
Vermont	50.4	0.2	98.7	14.3	0.2	14.1	69.5	1.9
Montana	47.3	0.2	98.9	13.6	0.2	14.4	71.9	0.0
Delaware	40.6	0.2	99.1	12.0	0.3	12.6	75.5	5.5
Idaho	38.8	0.2	99.3	15.7	0.1	15.2	67.1	1.8
New Hampshire	37.7	0.2	99.5	25.0	0.9	16.1	78.8	0.6
North Dakota	36.7	0.2	99.7	24.3	0.2	12.8	56.6	11.8
South Dakota	33.8	0.2	99.9	23.3	0.4	16.8	56.1	3.4
Nevada	28.2	0.1	100.0	20.6	1.5	16.6	62.4	5.2
Alaska	24.0	0.1	100.1	8.6	0.2	9.2	68.4	13.6
Wyoming	19.5	0.1	100.2	14.7	0.2	6.9	78.0	0.2
Virgin Islands	16.6	0.1	100.3	8.3	0.0	2.5	78.4	10.8

[1] The sum of percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.
[2] Aid to Families with Dependent Children. Includes dependent children under 21 years of age and adults in families with dependent children.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.6

Percent of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Number of recipients in thousands	Age			Sex		Race or ethnic origin[1]				
		Under 21 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
						Percent					
All jurisdictions	21,808.3	50.9	31.9	17.1	35.9	64.1	57.3	31.3	0.8	1.9	8.7
Alabama	316.2	42.4	28.7	29.0	32.6	67.4	38.4	61.5	0.0	0.1	0.0
Alaska	24.0	55.6	34.4	10.0	34.5	65.5	49.4	6.3	41.2	1.2	1.8
Arkansas	197.3	40.8	27.8	31.3	34.7	65.3	55.3	44.5	0.0	0.1	0.1
California	3,380.7	49.1	33.5	17.4	37.6	62.4	50.2	17.6	0.6	7.0	24.7
Colorado	147.3	47.7	30.8	21.5	35.0	65.0	54.1	11.3	0.7	0.4	33.5
Connecticut	217.4	53.4	30.6	16.0	35.2	64.8	70.0	30.0	0.0	0.0	0.0
Delaware	40.6	57.2	31.1	11.7	34.1	65.9	39.1	55.7	0.1	0.2	4.9
District of Columbia	98.3	53.1	34.9	11.9	33.7	66.3	2.9	97.1	0.0	0.0	0.0
Florida	561.9	46.9	28.3	24.8	29.6	70.4	42.1	48.2	0.2	5.9	3.6
Georgia	468.9	46.8	30.6	22.6	32.5	67.5	35.3	65.4	0.0	0.1	0.1
Hawaii	92.2	56.5	32.4	11.0	40.1	59.9	29.6	1.1	0.0	68.1	1.3
Idaho	38.8	50.7	33.2	16.1	34.9	65.1	89.4	0.6	2.8	0.6	6.6
Illinois	1,063.4	56.8	34.0	9.2	36.3	63.7	38.5	51.8	0.1	0.7	8.8
Indiana	284.0	52.9	31.6	15.4	33.3	66.7	68.0	29.7	0.1	0.3	1.8
Iowa	211.9	52.6	33.4	14.0	37.0	63.0	90.5	6.9	0.5	1.1	1.0
Kansas	141.7	53.3	31.4	15.3	35.8	64.2	73.2	22.4	0.9	0.0	3.4
Kentucky	408.2	50.6	34.0	15.3	37.4	62.6	98.7	1.3	0.0	0.0	0.0
Louisiana	416.2	48.4	29.9	21.7	34.5	65.5	29.3	70.7	0.0	0.0	0.0
Maine	124.4	47.3	34.4	18.4	37.5	62.5	—	—	—	—	—
Maryland	328.8	52.4	33.5	14.1	33.9	66.1	41.7	56.7	0.2	1.1	0.4
Massachusetts	522.9	46.9	30.3	22.9	34.1	65.9	73.9	12.2	0.1	1.2	12.5
Michigan	1,133.3	60.8	31.0	8.2	38.3	61.7	61.3	35.2	0.4	0.6	2.6
Minnesota	357.3	52.9	30.1	17.1	37.9	62.1	85.4	4.5	3.8	5.3	1.0
Mississippi	299.7	46.5	27.3	26.3	34.3	65.7	22.1	77.6	0.1	0.1	0.0
Missouri	356.0	34.2	28.2	37.6	34.2	65.8	65.8	33.8	0.2	0.0	0.2
Montana	47.3	50.4	33.9	15.7	36.1	63.9	83.6	0.0	14.5	0.6	1.2
Nebraska	93.9	52.7	30.7	16.6	36.0	64.0	75.3	16.5	3.7	0.9	3.7
Nevada	28.2	46.4	32.3	21.3	33.4	66.6	61.2	29.4	2.8	1.3	5.4
New Hampshire	37.7	42.6	33.9	23.5	33.4	66.6	97.1	1.1	0.6	0.1	0.8
New Jersey	581.4	56.8	30.7	12.5	34.8	65.2	37.1	41.8	0.2	0.4	20.5
New Mexico	87.3	49.6	32.8	17.6	35.3	64.7	86.8	4.7	8.5	0.0	0.0
New York	2,242.1	51.5	32.0	16.5	36.4	63.6	66.4	26.6	0.5	0.3	6.2
North Carolina	343.2	47.8	33.2	19.1	32.5	67.5	38.7	58.7	2.4	0.1	0.1
North Dakota	36.7	52.9	26.3	20.8	36.8	63.2	81.4	0.4	17.2	0.5	0.5
Ohio	1,045.1	55.8	34.5	9.6	37.3	62.7	68.7	29.4	0.3	0.3	1.3

See footnotes at end of table.

Table 4.6—Continued

Percent of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Number of recipients in thousands	Age			Sex		Race or ethnic origin[1]				
		Under 21 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
					Percent						
Oklahoma	270.0	46.9	31.6	21.4	32.3	67.7	67.8	23.2	7.5	0.4	1.1
Oregon	152.5	53.3	32.8	13.9	34.9	65.1	85.4	6.9	3.4	1.7	2.6
Pennsylvania	1,071.0	55.6	32.7	11.8	37.7	62.3	61.9	31.6	0.0	0.8	5.6
Puerto Rico	1,571.9	45.4	51.1	3.5	37.6	62.4	—	—	—	—	—
Rhode Island	100.8	47.4	25.5	27.1	35.2	64.8	74.2	13.7	0.1	3.1	8.8
South Carolina	237.6	44.4	31.4	24.2	32.4	67.6	29.6	70.2	0.1	0.0	0.0
South Dakota	33.8	46.8	27.7	25.5	35.1	64.9	68.4	0.1	31.5	0.0	0.0
Tennessee	362.1	48.5	31.0	20.4	33.9	66.1	57.6	42.1	0.0	0.2	0.1
Texas	761.3	44.3	27.5	28.2	33.5	66.5	38.4	31.1	0.1	0.8	29.7
Utah	72.2	58.1	31.7	10.2	37.4	62.6	85.6	0.1	3.4	1.4	9.5
Vermont	50.4	49.4	34.2	16.4	36.9	63.1	99.0	0.3	0.1	0.5	0.1
Virgin Islands	16.6	64.6	27.1	8.3	28.0	72.0	—	—	—	—	—
Virginia	303.0	48.6	31.9	19.5	33.9	66.1	43.2	55.3	0.1	1.0	0.4
Washington	326.4	53.1	34.2	12.8	36.8	63.2	82.8	7.4	3.8	1.4	4.7
West Virginia	211.4	52.0	36.4	11.6	39.3	60.7	94.4	5.6	0.0	0.0	0.0
Wisconsin	473.3	49.9	34.5	15.6	38.0	62.0	74.9	17.0	2.8	1.9	3.5
Wyoming	19.5	54.6	29.4	16.0	33.1	66.9	83.8	3.0	1.5	0.2	11.5

[1] The race or ethnic origin of significant numbers of recipients in some reporting States was unknown. The Office of the Actuary estimated the number of recipients by race or ethnic origin for these States. Data by race or ethnic origin, therefore, should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Service coverage and limitations

Title XIX regulations require each Medicaid program to offer a basic set of services to all categorically needy persons. States receive Federal financial participation for these basic services as well as certain optional services they may elect to cover. States may limit the scope of coverage for both required and optional services, but they must make service coverage uniform throughout their State. However, this "statewideness" rule may be waived for a limited period of time for the purpose of conducting special demonstration studies. Section 1915 also authorizes waivers of statewideness under federally approved home and community-based service programs and certain programs limiting recipients' freedom of choice.

All States participating in Medicaid must cover the following basic services for all categorically needy recipients.

- Inpatient hospital services, other than services in an institution for tuberculosis or mental disease, that are ordinarily furnished in a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or dentist. The hospital must be licensed or formally approved as a hospital by a designated State standard-setting authority, and it must either be qualified to participate under Medicare or have been determined to currently meet the requirements of participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid program (42 CFR 440.10).
- Outpatient hospital services, including preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by or under the direction of a physician or dentist to a hospital outpatient. The hospital must meet the same requirements as for inpatient services: It must be licensed or formally approved as a hospital and must either be qualified to participate under Medicare or meet the requirements for such participation (42 CFR 440.20[a]).
- Rural health clinic services in certified clinics that are furnished by a physician or by a physician's assistant, nurse practitioner, nurse-midwife, or other specialized nurse practitioner in States where those professionals are not prohibited by State law from furnishing primary health care (42 CFR 440.20 [b]).
- Other laboratory and X-ray services, including professional and technical laboratory and radiological services, that are ordered by a physician or other licensed practitioner within the scope of his or her practice as defined by State law. These services must be provided to a patient by or under the direction of a physician or other licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. To be eligible for Medicaid coverage, services must be provided to a patient by a laboratory that is qualified to participate under Medicare or is determined to meet the requirements for such participation (42 CFR 440.30).
- Skilled nursing facility (SNF) services for individuals 21 years of age or over, other than services in an institution for tuberculosis or mental disease. These services must be ordered by and furnished under the direction of a physician. The facility must be qualified for participation in Medicaid (42 CFR 440.40 [a]).
- Physicians' services, whether provided in the office, the patient's home, a hospital, an SNF, or elsewhere. Physicians' services are defined to include services provided within the scope of practice of the profession as defined by State law and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy (42 CFR 440.50).
- Early and periodic screening, diagnosis, and treatment (EPSDT) for recipients under age 21. EPSDT includes screening and diagnostic services to determine physical or mental defects as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (42 CFR 440.40 [b]).
- Family planning services and supplies for individuals of childbearing age who are eligible for Medicaid and desire such services and supplies (42 CFR 440.40 [c]).
- Home health services provided in the patient's residence by a licensed agency. These include nursing services provided on a part-time or intermittent basis by a home health agency or registered nurse (if there is no home health agency in the area); home health aide services provided by a home health agency; and medical supplies, equipment, and appliances suitable for use in the home (42 CFR 440.70 and 42 CFR 441.15).
- Services concerned with the management of the care of mothers and newborns that are furnished by a licensed nurse-midwife within the scope of practice authorized by State law (42 CFR 440.165).

Beginning October 1, 1981, States with a medically needy program must, at a minimum, cover the following services (42 CFR 440.220): prenatal care and delivery services for pregnant women and ambulatory services as defined in the State plan for individuals under age 18 and individuals entitled to institutional services. Home health services for any individual entitled to SNF services must also be covered. More comprehensive benefits are required in States that provide institutional services for mental diseases or mental retardation to the medically needy.

In addition to federally required services, each State may offer coverage of certain optional services:

- Medical or other remedial care provided by licensed practitioners within the scope of practice as defined under State law. These practitioners may include, among others, chiropractors (limited coverage), optometrists, and podiatrists (42 CFR 440.60).

- Home health services in addition to those required under 42 CFR 440.70. Specifically included are physical therapy, occupational therapy, speech pathology, and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services (42 CFR 440.70[b][4]).
- Private-duty nursing services, defined as nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician. These services may be provided to a patient in his or her own home or in a hospital or SNF when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF (42 CFR 440.80).
- Clinic services, that is, preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility that is not part of a hospital but that is organized and operated to provide medical care to outpatients (42 CFR 440.90).
- Dental services in addition to those required to be provided to persons under 21 years of age in the State's EPSDT program (42 CFR 440.100).
- Physical therapy and related services, including occupational therapy and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary. These services must be rendered by or under the supervision of an individual qualified (licensed, registered, or certified, as appropriate) in the practice of the appropriate profession and under the prescription or referral of a physician (42 CFR 440.110).
- Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses. Prescribed drugs that may be provided are simple or compounded substances or mixtures of substances prescribed by a physician or other licensed practitioner (42 CFR 440.120).
- Other diagnostic, screening, preventive, and rehabilitative services (42 CFR 440.130).
- Inpatient hospital services, SNF services, and intermediate care facility (ICF) services to persons 65 years of age or over in institutions for tuberculosis or mental disease (42 CFR 440.140).
- ICF services, other than services in an institution for tuberculosis or mental diseases, for the physically ill or mentally retarded (42 CFR 440.150).
- Inpatient psychiatric hospital services for persons under age 21 (42 CFR 440.160).
- Other medical or remedial care recognized under State law. Such additional items and services include transportation, emergency hospital services, nonprofessional personal care services prescribed by a physician and performed under the supervision of a registered nurse in the home, Christian Science sanatoriums and nursing services, and SNF services for persons under 21 years of age (42 CFR 440.170).
- Home and community-based services (under waiver agreement) that an individual would need to avoid institutionalization (42 CFR 441, subpart G).

The optional services each jurisdiction offered the categorically needy and medically needy as of October 1986 are presented in Table 4.7. The most frequently offered optional services based on the number of States and territories offering them, were prescribed drugs (51), optometrists' services (50), clinic services (50), and ICF services (50). The least offered were hospice services (2) and case management services (3).

Once a State has selected a benefit package, Federal regulations require that the State plan specify the amount and/or duration of each covered service. Benefits must be sufficient in amount, duration, and scope to reasonably achieve their purpose (42 CFR 440.230). They also must be comparable for all categorically needy recipients and within each medically needy group (42 CFR 440.240). States may not impose limits on the basis of "diagnosis, type of illness, or condition." However, under section 1915 waiver authority, States may target home and community-based waiver programs to such groups as AIDS, Alzheimer's, or mentally ill patients. Within these general guidelines, States are free to set whatever service limits they choose. Not all limits are absolute, and some can be exceeded if need is confirmed.

Limitations imposed by States on five mandatory services (inpatient hospital, outpatient hospital, home health, physicians', and SNF services) are shown in Table 4.8. Forty-six States (including the District of Columbia) limit inpatient hospital services, 42 States limit outpatient hospital services, and 45 limit physicians' services. Of services authorized under home health care, 35 States limit part-time nursing services; 35 limit aide services; 40 either limit or do not cover physical, occupational, or speech and hearing therapy; and 44 limit medical supplies and equipment. Thirty-six States limit services covered in SNF's.

The limitations imposed by States on prescription drugs as of March 1986 are shown in Table 4.9. Two States, Alaska and Wyoming, did not provide prescribed drugs as a separate service to Medicaid recipients. Twenty-one States imposed a fixed or variable copayment on each prescription; 12 limited the number of prescriptions per recipient per month. Thirty-one States set limits on the number of days that must elapse before a single prescription can be refilled. All but 10 excluded most over-the-counter drugs from coverage, and 23 employed formulary restrictions of varying stringency.

Prior to October 1, 1982, States were permitted to charge Medicaid recipients copayments, except for mandatory services provided to the categorically needy. Section 131 of the Tax Equity and Fiscal Responsibility Act (TEFRA) now enables States to charge copayments to both categorically and medically needy recipients for all services except the following: services provided to individuals under age 18 (or up to age 21 at State

Table 4.7
Medicaid services, by jurisdiction: October 1, 1986

Basic required Medicaid services

Medicaid recipients receiving federally supported financial assistance must receive at least these services:
- Inpatient hospital services.
- Outpatient hospital services.
- Rural health clinic services.
- Other laboratory and X-ray services.
- Skilled nursing facility services and home health services for individuals 21 and older.
- Early and periodic screening, diagnosis, and treatment for individuals under 21.
- Family planning services and supplies.
- Physician services.
- Nurse Midwife services.

Optional services in State Medicaid programs

• CN[2]
+ Both CN and MN[3]

FMAP	Basic required Medicaid services see above		Podiatrists' services	Optometrists' services	Chiropractors' services	Other practitioners' services	Private duty nursing	Clinic services	Dental services	Physical therapy	Occupational therapy	Speech, hearing, and language disorder	Prescribed drugs	Dentures	Prosthetic devices	Eyeglasses	Diagnostic services
72.41	•	Alabama		•				•					•		•	•	
50.00	•	Alaska		•	•			•	•	•	•	•			•	•	
		American Samoa[4]															
62.13		Arizona[5]															
74.02	+	Arkansas		+	+	+		+	+				+	+	+	+	
50.00	+	California	+	+	+	+		+	+	+	+	+	+	+	+	+	+
50.00	•	Colorado	•	•		•		•	•				•			•	
50.00	+	Connecticut	+	+	+	+	+	+	+	+		+	+	+	+	+	+
50.00	•	Delaware	•	•		•	•	•					•		•		•
50.00	+	D.C.	+	+		+	+	+		+	+	+	+		+	+	+
55.54	+	Florida	+	+		+		+	+			+	+	+	+	+	
64.54	+	Georgia	+	+		+		+	+				+	+	+	+	
50.00	•	Guam		•				•	•			•	•			•	
51.29	+	Hawaii	+	+		+		+	+	+	+	+	+	+	+	+	+
71.08	•	Idaho	•	•	•	•		•		•	•		•				
50.00	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
62.92	•	Indiana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
60.39	+	Iowa	+	+	+	+		+	+	+	+	+	+	+	+	+	+
51.39	+	Kansas	+	+	+	+		+	+	+	+	+	+	+	+	+	
70.75	+	Kentucky	+	+		+		+	+	+	+	+	+		+	+	+
65.77	+	Louisiana		+				+	+				+	+	+	+	
68.07	+	Maine	+	+	+	•	+		+	+	+	+	+		+	+	+
50.00	+	Maryland	+	+				+	+	+		+	+	+	+	+	
50.00	+	Massachusetts	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
56.88	+	Michigan	+	+	+	+		+	+	+	+	+	+	+	+	+	+
52.98	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
78.50	•	Mississippi		•					•				•			•	
59.85	•	Missouri	•	•				•	•				•	•	•	•	
67.44	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+
58.06	+	Nebraska	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
50.00	•	Nevada	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
53.28	+	New Hampshire	+	+	+	+	+	+	+	+	+	+	+		+	+	+
50.00	+	New Jersey	+	+	+	+		+	+	+	+	+	+	+	+	+	+
69.68	•	New Mexico	•	•		•		•	•	•			•	•	•	•	
50.00	+	New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+
69.18	+	North Carolina	+	+	+			+	+				+	+		+	+
56.41	+	North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+
50.00	+	N. Mariana Islands		+				+	+	+			+	+	+	+	
58.27	•	Ohio	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
59.86	+	Oklahoma	+	+		+		+	+				+		+	+	
62.47	+	Oregon	+	+	+	+	+	+	+	+	+	+	+		+	+	+
57.28	+	Pennsylvania	+	+	+			+	•				•	•	•		
50.00	+	Puerto Rico[6]						+									
55.38	+	Rhode Island	•	+					+				+	+	+	•	
72.23	+	South Carolina	+	+				+	+				+		+	+	
67.45	•	South Dakota			•			•	•	•			•	•	•		
70.26	+	Tennessee						+		+	+	+	+	+	+	+	
55.16	+	Texas	+	+	+	+							+		+	+	
73.21	+	Utah	+	+		+		+	+	+		+	+	+	+	+	+
67.37	+	Vermont	+	+	+	+		+		+	+	+	+		+	+	
50.00	+	Virgin Islands[4]						+					+	+	+	+	
51.86	+	Virginia	+	+				+		+	+	+	+				
52.52	+	Washington	+	+	•	+	+	+	+	+		•	+	+	+	+	+
72.59	+	West Virginia	+	+	+	+	+	+	+	+		+	+	+	+	+	
57.58	+	Wisconsin		•	•	•	•	+	•	+	+	+	+	•	+	•	•
54.20	•	Wyoming		•				•		•					•		
•	14	•	10	15	8	10	5	14	12	8	5	7	14	8	12	13	3
+	40	+	31	35	20	25	14	36	31	28	22	26	37	27	35	34	20
	54	Total	41	50	28	35	19	50	43	36	27	33	51	35	47	47	23

Federal Medicaid assistance percentage (FMAP): Rate of Federal financial participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Effective October 1, 1986 through September 30, 1987 (Fiscal year 1987).
Categorically Needy: Individuals receiving federally supported financial assistance.
Medically Needy: Individuals who are eligible for medical but not financial assistance.
American Samoa operates under a special Medicaid waivered program.
Arizona operates a medical assistance program under a Section 1115 demonstration project.
All services are provided through public health facilities.
All services indicated as available to the Medically Needy are not available to all Medically Needy Groups.

Table 4.7 — Continued
Medicaid services, by jurisdiction: October 1, 1986

Basic required Medicaid services

Federal financial participation is also available to States electing to expand their Medicaid programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Optional services in State Medicaid programs

Screening services	Preventive services	Rehabilitative services	Services for age 65 or older in mental institution			Intermediate care facility services	ICF for mentally retarded	Inpatient psychiatric services for under age 22	Christian Science nurses	Christian Science sanitoria	SNF for under age 21	Emergency hospital services	Personal care services	Transportation services	Case management services	Hospice services	Total additional services	
			A. Inpatient hospital services	B. SNF services	C. ICF services													
	•			•	•	•	•				•	•	•	•			14	AL
			•			•	•	•			•	•	•	•			17	AK
																		AS
																		AZ
		+	+	•	•	•	•	+			•	+	•	+			20	AR
+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			29	CA
			•	•	•	•	•	•			•	•		•			16	CO
+	+	+	+			+	+	+		+	+			+			24	CT
			•		•	•	•				•	•		•			15	DE
+	+	+	+	+	+	+	+	+			+	+	+	+			25	DC
		+	+			+	+			+		+		+			17	FL
						+	+				+			+			13	GA
												•					7	GU
+	+	+				+	+				+	+	+	+			22	HI
		•			•	•	•				•	•					14	ID
	+	+	+	+	+	+	+	+		+	+	+		+			27	IL
•	•	•	•			•	•	•	•	•	•	•	•	•			28	IN
	+	+	•			•	•	•			+	+		+			23	IA
		+	+		+	+	+	+			+	+	+				22	KS
	+	+	+	+	+	+	+	+			+	+		+			23	KY
		+	•	•	•	•	•	•			•			+			16	LA
+	+	+				+	+	+	+	+	+	•	+	+			25	ME
			+			+	+	+			+	+	+	+			18	MD
+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			30	MA
		+	+	+	+	+	+	+		+	+	+	+	+			26	MI
+	+	+	+	+	+	+	+	+		+	+	+	+	+			29	MN
						•	•			•	•	•		•			10	MS
			•			•	•	•					•				13	MO
+	+	+	+	+	+	+	+	+			+	+	+	+			27	MT
			+	+	+	+	+	+			+	+	+				23	NB
		•	•	•	•	•	•				•	•	•	•			24	NV
+	+	+	+		+	+	+		+	+	+	+	+				26	NH
+	+	+	•	•	•	•	•	•		•	•	+	+	+			28	NJ
		•				•	•				•	•		•			16	NM
+	+	+	+			+	+	+			+	+	+	+		+	26	NY
+	+	+	+		+	+	+	+			+		+	+			20	NC
+	+	+	+			+	+	+			+	+		+		+	25	ND
												+	+	+			11	NMI
		•	•	•	•	•	•	•		•	•	•		•			25	OH
		+	+			+	+	+			+		+	+			16	OK
	+	+	•			+	+	+		+	+	+	+	+	+		26	OR
			+	+	+	+	+	+			+	+					16	PA
																	1	PR
		+	+	+	+	+	+	+			+			+	+		17	RI
		+	+	+	+	+	+	+			+	+		+			17	SC
			•	•	•	•	•				•	•	•	•			16	SD
			+	+	+	+	+	+	+	+	+	+	+	+			20	TN
		+				+	+			+	+	+	+	+			15	TX
+	+	+	+	+	+	+	+	+			+	+	+	+			25	UT
			+			+	+	+			+	+		+			18	VT
														+			6	VI
			•	•	•	+	•			+	+	+					15	VA
	+	+	+	+	+	+	+	+			+	+		+			25	WA
						+	+	+			+	+		+	+		20	WV
•	•	•	•			+	+	•		+	+	•	+	+			26	WI
		•	•			•					•			•			9	WY
2	3	7	15	9	11	18	18	9	1	5	15	15	7	11	0	0		
14	19	28	26	15	18	32	31	27	5	13	33	29	22	34	3	2		
16	22	35	41	24	29	50	49	36	6	18	48	44	29	45	3	2		

NOTE: The data shown were recorded by individual Regional Offices and compiled by the Office of Intergovernmental Affairs.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Intergovernmental Affairs.

option), services related to pregnancy (or any services provided to pregnant women), services furnished to institutionalized individuals who are required to expend all of their income above their personal needs allowance, emergency services, and family planning services and supplies.

Table 4.8

Limits on selected mandatory Medicaid services, by jurisdiction: March 1986

Medicaid jurisdiction	Limits on inpatient hospital services								
			Prior authorization required						
	Limits	Days per year	Elective procedures	Specific procedures	Number of outpatient procedures covered	Weekend admissions, preoperation days	Dental procedures	Sterilization	Other
Alabama	Y	12	N	Y	N	Y	Y	N	N
Alaska	Y		Y	Y	N	Y	N	N	Y
Arkansas	Y	35	N	Y	N	N	N	N	Y
California	Y		N	Y	Y	N	N	N	Y
Colorado	Y		N	Y	N	N	N	N	Y
Connecticut	Y		N	N	Y	Y	N	N	N
Delaware	Y		Y	Y	N	Y	N	N	Y
District of Columbia	Y		N	N	N	N	N	N	Y
Florida	Y	45	N	N	N	N	N	N	Y
Georgia	Y		N	Y	N	N	N	Y	Y
Hawaii	Y		N	N	N	N	N	N	Y
Idaho	Y	40	N	N	N	N	N	N	N
Illinois	Y		N	N	Y	Y	N	N	N
Indiana	Y		N	Y	N	N	N	N	N
Iowa	Y		N	Y	N	N	Y	Y	Y
Kansas	Y		N	N	N	N	N	N	N
Kentucky	Y	[1]14	N	N	Y	Y	N	N	Y
Louisiana	Y		N	Y	Y	N	N	N	Y
Maine	N		N	N	N	N	N	N	N
Maryland	Y		N	Y	N	N	N	N	Y
Massachusetts	N		N	N	N	N	N	N	N
Michigan	Y		Y	Y	N	N	Y	N	Y
Minnesota	Y		N	Y	N	N	Y	N	Y
Mississippi	Y	15	N	N	N	Y	N	N	N
Missouri	Y		N	N	Y	Y	N	N	Y
Montana	Y		N	N	N	N	N	N	Y
Nebraska	Y		N	N	N	N	Y	N	Y
Nevada	Y		N	N	N	N	N	N	Y
New Hampshire	Y		N	N	Y	N	N	N	Y
New Jersey	Y		N	Y	N	N	N	N	Y
New Mexico	Y		N	Y	N	N	N	N	Y
New York	Y		Y	N	Y	Y	N	N	Y
North Carolina	Y		Y	Y	N	N	Y	Y	Y
North Dakota	N		N	N	N	N	N	N	N
Ohio	Y		Y	N	N	N	N	N	Y
Oklahoma	Y		N	N	N	N	N	N	Y
Oregon	Y	18	Y	Y	N	N	Y	Y	Y
Pennsylvania	Y		N	N	Y	Y	N	Y	Y
Rhode Island	Y		N	Y	N	N	Y	Y	Y
South Carolina	Y		N	Y	Y	N	N	N	Y
South Dakota	N		N	N	N	N	N	N	N
Tennessee	Y	14	N	N	N	Y	N	N	N
Texas	Y	[1]30	N	N	N	N	N	N	Y
Utah	Y		N	Y	N	N	N	N	Y
Vermont	Y		N	Y	N	N	Y	N	Y
Virginia	Y	21	N	N	N	N	N	N	Y
Washington	Y		Y	N	N	N	N	N	Y
West Virginia	Y	60	N	N	N	N	N	N	N
Wisconsin	Y		N	Y	N	N	N	N	Y
Wyoming	Y		N	Y	N	Y	N	N	Y

See footnotes at end of table.

Table 4.8—Continued

Limits on selected mandatory Medicaid services, by jurisdiction: March 1986

Medicaid jurisdiction	Limits on outpatient hospital services						
	Limits	Visits per year	Special[2]	Specific[3]	Psychiatric	Sterilization	Other
Alabama	Y	3	N	Y	N	N	N
Alaska	N		N	N	N	N	N
Arkansas	Y	18	Y	N	N	N	Y
California	Y		Y	N	N	N	Y
Colorado	Y		N	N	N	N	Y
Connecticut	Y		Y	N	Y	N	Y
Delaware	N		N	N	N	N	N
District of Columbia	Y		N	N	N	N	Y
Florida	Y		N	N	N	N	Y
Georgia	Y		N	Y	N	Y	Y
Hawaii	Y	48	N	Y	Y	N	Y
Idaho	Y	6	N	N	N	N	N
Illinois	N		N	N	N	N	N
Indiana	Y		N	Y	N	N	N
Iowa	Y		N	N	N	Y	Y
Kansas	Y		Y	N	N	N	Y
Kentucky	Y		Y	N	N	N	Y
Louisiana	Y		N	N	N	N	Y
Maine	N		N	N	N	N	N
Maryland	Y		Y	Y	Y	N	Y
Massachusetts	N		N	N	N	N	N
Michigan	Y		Y	Y	Y	N	Y
Minnesota	Y		N	N	N	N	Y
Mississippi	Y	6	N	N	N	N	Y
Missouri	Y	24	Y	Y	N	N	Y
Montana	Y		N	N	N	N	Y
Nebraska	Y		N	Y	N	N	Y
Nevada	Y		N	N	N	N	Y
New Hampshire	Y	12	N	N	N	N	N
New Jersey	Y		N	Y	N	N	Y
New Mexico	Y		Y	Y	N	N	N
New York	N		N	N	N	N	N
North Carolina	Y	24	Y	Y	Y	Y	Y
North Dakota	N		N	N	N	N	N
Ohio	Y		N	Y	N	N	Y
Oklahoma	Y		N	N	N	N	Y
Oregon	Y		N	N	N	N	Y
Pennsylvania	Y		Y	Y	Y	N	Y
Rhode Island	Y		N	N	N	Y	Y
South Carolina	Y	18	N	N	N	N	N
South Dakota	N		N	N	N	N	N
Tennessee	Y	30	N	N	N	N	N
Texas	Y		N	N	N	N	Y
Utah	Y		N	Y	N	Y	N
Vermont	Y		N	N	N	N	Y
Virginia	Y		Y	N	N	N	Y
Washington	Y		N	N	N	N	Y
West Virginia	Y		N	N	N	N	Y
Wisconsin	Y		N	Y	N	N	Y
Wyoming	Y		Y	N	N	N	Y

See footnotes at end of table.

Table 4.8—Continued

Limits on selected mandatory Medicaid services, by jurisdiction: March 1986

Medicaid jurisdiction	Limits on home health services							
	Medical supplies or equipment				Physical therapy, occupational therapy, and speech and hearing services			
	Limits	Quantity or dollars	Restricted supply list	Prior authorization required	Limits	Visits	Services	Prior authorization required
Alabama	Y	N	Y	N	N	N	N	N
Alaska	Y	N	N	Y	Y	N	N	Y
Arkansas	N	N	N	N	Y	N	Y	N
California	Y	Y	N	Y	Y	N	Y	Y
Colorado	Y	N	N	Y	Y	N	N	Y
Connecticut	N	N	N	N	N	N	N	N
Delaware	N	N	N	N	N	N	N	N
District of Columbia	Y	Y	N	Y	Y	N	N	N
Florida	Y	Y	Y	N	N	N	N	N
Georgia	Y	Y	Y	Y	Y	Y	Y	Y
Hawaii	Y	Y	N	Y	Y	Y	Y	Y
Idaho	Y	Y	N	Y	Y	N	Y	N
Illinois	Y	N	N	Y	Y	N	N	N
Indiana	Y	N	N	Y	Y	N	Y	Y
Iowa	Y	N	N	N	Y	N	N	Y
Kansas	Y	N	N	N	Y	N	N	N
Kentucky	Y	N	N	Y	Y	N	N	N
Louisiana	Y	N	N	Y	Y	N	Y	N
Maine	N	N	N	N	N	N	N	N
Maryland	Y	N	N	N	Y	Y	N	Y
Massachusetts	Y	N	N	Y	Y	N	N	N
Michigan	Y	N	N	N	Y	N	Y	N
Minnesota	Y	N	N	Y	Y	N	N	N
Mississippi	Y	Y	N	N	Y	Y	Y	N
Missouri	Y	N	N	N	Y	N	Y	N
Montana	Y	N	N	Y	Y	Y	Y	N
Nebraska	Y	Y	N	Y	N	N	N	N
Nevada	Y	N	N	Y	Y	N	N	Y
New Hampshire	Y	N	N	Y	Y	Y	N	N
New Jersey	Y	N	N	Y	Y	N	N	Y
New Mexico	Y	N	N	Y	Y	N	N	Y
New York	Y	N	N	N	Y	N	N	Y
North Carolina	Y	N	Y	Y	Y	N	N	N
North Dakota	N	N	N	N	N	N	N	N
Ohio	Y	N	N	N	Y	Y	N	Y
Oklahoma	Y	N	Y	N	N	N	N	N
Oregon	Y	N	N	Y	Y	N	N	Y
Pennsylvania	Y	N	N	Y	Y	N	N	N
Rhode Island	Y	N	N	Y	Y	N	N	Y
South Carolina	Y	N	N	Y	Y	N	Y	N
South Dakota	Y	N	Y	N	Y	N	Y	N
Tennessee	N	N	N	N	Y	Y	N	N
Texas	Y	N	N	Y	N	N	N	N
Utah	Y	Y	Y	Y	Y	Y	Y	Y
Vermont	Y	N	Y	N	Y	N	N	N
Virginia	Y	N	Y	Y	Y	N	Y	N
Washington	Y	N	N	N	Y	Y	Y	Y
West Virginia	Y	N	N	Y	N	N	N	N
Wisconsin	Y	N	N	Y	Y	N	N	Y
Wyoming	Y	N	Y	N	Y	N	N	N

See footnotes at end of table.

Table 4.8—Continued

Limits on selected mandatory Medicaid services, by jurisdiction: March 1986

Medicaid jurisdiction	Limits on home health services—Continued						
	Part-time nursing			Aide services			
	Limits	Number of visits	Prior authorization required	Limits	Number of visits or hours	Homemaker visits	Prior authorization required
Alabama	Y	Y	Y	Y	Y	N	Y
Alaska	Y	N	Y	Y	N	N	Y
Arkansas	N	N	N	N	N	N	N
California	Y	Y	Y	Y	Y	N	Y
Colorado	Y	N	Y	Y	N	N	Y
Connecticut	Y	N	N	Y	Y	N	N
Delaware	N	N	N	N	N	N	N
District of Columbia	N	N	N	Y	Y	N	Y
Florida	N	N	N	N	N	N	N
Georgia	Y	Y	Y	Y	Y	Y	Y
Hawaii	Y	N	N	N	N	N	N
Idaho	Y	Y	N	Y	Y	N	N
Illinois	Y	N	Y	Y	N	N	Y
Indiana	Y	N	Y	Y	N	N	N
Iowa	N	N	N	N	N	N	N
Kansas	Y	N	N	Y	N	N	N
Kentucky	Y	N	N	Y	N	Y	N
Louisiana	Y	Y	N	Y	Y	N	N
Maine	N	N	N	N	N	N	N
Maryland	Y	N	N	Y	Y	N	N
Massachusetts	Y	N	Y	Y	N	N	Y
Michigan	N	N	N	N	N	N	N
Minnesota	N	N	N	N	N	N	N
Mississippi	Y	N	N	Y	N	N	N
Missouri	Y	Y	N	Y	Y	N	N
Montana	Y	Y	N	Y	Y	N	N
Nebraska	N	N	N	Y	N	N	Y
Nevada	Y	N	Y	Y	N	N	Y
New Hampshire	Y	Y	N	Y	Y	N	N
New Jersey	Y	N	Y	Y	N	N	Y
New Mexico	Y	N	Y	Y	N	N	Y
New York	Y	N	Y	Y	N	N	Y
North Carolina	Y	N	N	Y	N	N	N
North Dakota	N	N	N	N	N	N	N
Ohio	N	N	N	N	N	N	N
Oklahoma	Y	Y	N	Y	Y	N	N
Oregon	Y	N	Y	Y	N	N	Y
Pennsylvania	Y	Y	N	Y	Y	N	N
Rhode Island	Y	N	Y	Y	N	N	Y
South Carolina	Y	Y	N	Y	N	Y	N
South Dakota	N	N	N	N	N	N	N
Tennessee	Y	Y	N	Y	Y	N	N
Texas	Y	Y	Y	Y	Y	N	Y
Utah	N	N	N	N	N	N	N
Vermont	Y	N	N	Y	N	N	N
Virginia	N	N	N	N	N	N	N
Washington	Y	Y	N	Y	Y	N	N
West Virginia	N	N	N	N	N	N	N
Wisconsin	Y	N	Y	Y	N	N	Y
Wyoming	Y	N	N	N	N	N	N

See footnotes at end of table.

Table 4.8—Continued

Limits on selected mandatory Medicaid services, by jurisdiction: March 1986

Medicaid jurisdiction	Limits	Limits on physicians' services					
		Visits					
		Inpatient hospital	Long-term care facility[4]	Office[4]	Home[4]	Emergency room[4]	Any setting other than inpatient hospital[4]
Alabama	Y	[5]1					12
Alaska	Y						
Arkansas	Y		18	18	18		
California	Y						
Colorado	N						
Connecticut	Y		4				
Delaware	Y						
District of Columbia	Y						
Florida	Y	[5]1	12				
Georgia	Y	[5]1	12	12			
Hawaii	Y		24				
Idaho	Y						
Illinois	Y						
Indiana	Y						
Iowa	Y						
Kansas	Y			12			
Kentucky	Y						
Louisiana	Y						12
Maine	N						
Maryland	Y						
Massachusetts	Y						
Michigan	Y		12				
Minnesota	Y						
Mississippi	Y	[5]1	36				12
Missouri	Y					12	
Montana	Y						
Nebraska	Y						
Nevada	Y			24			
New Hampshire	Y	[4]12					18
New Jersey	Y						
New Mexico	Y	[5]2					
New York	N						
North Carolina	Y						24
North Dakota	N						
Ohio	Y	[4]12	12		12		
Oklahoma	Y	[5]1	24	48	48		
Oregon	Y						
Pennsylvania	Y						
Rhode Island	Y						
South Carolina	Y						18
South Dakota	Y						
Tennessee	Y			24			
Texas	Y						
Utah	Y						
Vermont	Y		12				
Virginia	Y	[6]21					
Washington	Y	[5]1					
West Virginia	N						
Wisconsin	Y						
Wyoming	Y		12				

See footnotes at end of table.

Table 4.8—Continued

Limits on selected mandatory Medicaid services, by jurisdiction: March 1986

Medicaid jurisdiction	Limits on physicians' services—Continued							
	Prior authorization required							
	Specific procedures	Elective procedures	Specific settings	Care outside State	Psychiatric services	Injections	Sterilization	Other
Alabama	Y	N	N	Y	N	N	N	Y
Alaska	N	Y	N	N	N	N	Y	N
Arkansas	N	Y	N	N	N	N	N	Y
California	Y	Y	Y	N	Y	N	N	Y
Colorado	N	N	Y	Y	N	N	N	N
Connecticut	N	N	N	N	N	N	N	Y
Delaware	N	N	N	N	N	N	N	Y
District of Columbia	Y	Y	N	N	Y	N	N	Y
Florida	N	Y	Y	N	N	N	N	Y
Georgia	Y	Y	Y	Y	N	N	N	Y
Hawaii	Y	Y	N	Y	Y	N	Y	Y
Idaho	Y	Y	N	Y	N	N	N	Y
Illinois	N	N	N	N	N	N	N	Y
Indiana	Y	N	N	N	N	N	N	Y
Iowa	Y	N	N	N	N	Y	Y	Y
Kansas	N	N	N	N	N	N	N	Y
Kentucky	N	N	N	N	N	N	N	Y
Louisiana	N	N	N	N	N	N	N	Y
Maine	N	N	N	N	N	N	N	N
Maryland	Y	N	N	N	N	Y	N	Y
Massachusetts	N	Y	N	N	N	N	N	Y
Michigan	N	N	N	N	N	N	N	Y
Minnesota	Y	N	N	N	N	N	N	Y
Mississippi	N	N	N	N	N	N	N	Y
Missouri	Y	N	N	Y	N	N	N	Y
Montana	N	N	N	N	N	N	N	Y
Nebraska	Y	N	N	N	Y	Y	Y	Y
Nevada	N	N	N	N	N	N	N	Y
New Hampshire	Y	N	N	N	N	N	N	Y
New Jersey	Y	Y	N	N	Y	N	N	Y
New Mexico	Y	Y	N	N	N	N	N	Y
New York	N	N	N	N	N	N	N	N
North Carolina	Y	N	N	Y	Y	Y	Y	Y
North Dakota	N	N	N	N	N	N	N	N
Ohio	N	N	N	N	N	N	N	Y
Oklahoma	N	N	N	N	N	N	N	Y
Oregon	Y	Y	N	Y	N	N	N	Y
Pennsylvania	N	N	N	N	N	N	N	Y
Rhode Island	Y	N	N	Y	N	N	Y	Y
South Carolina	N	N	N	N	N	N	N	Y
South Dakota	N	N	N	N	N	N	N	Y
Tennessee	N	N	N	N	N	N	N	Y
Texas	N	N	N	N	N	N	N	Y
Utah	Y	N	Y	Y	N	N	Y	Y
Vermont	Y	N	N	N	N	N	Y	Y
Virginia	Y	N	N	N	Y	N	N	Y
Washington	Y	Y	Y	Y	N	N	N	Y
West Virginia	N	N	N	N	N	N	N	N
Wisconsin	Y	N	N	Y	Y	N	Y	Y
Wyoming	N	N	N	Y	N	N	N	Y

See footnotes at end of table.

Table 4.8—Continued

Limits on selected mandatory Medicaid services, by jurisdiction: March 1986

Medicaid jurisdiction	Limits on skilled nursing facility services			
	Limits	Prior authorization required	Periodic reauthorization required	Other
Alabama	Y	Y	N	N
Alaska	Y	Y	Y	N
Arkansas	N	N	N	N
California	Y	Y	Y	N
Colorado	Y	Y	Y	N
Connecticut	N	N	N	N
Delaware	N	N	N	N
District of Columbia	Y	N	N	Y
Florida	N	N	N	N
Georgia	Y	Y	N	N
Hawaii	Y	Y	N	N
Idaho	N	N	N	N
Illinois	Y	N	N	Y
Indiana	Y	N	N	Y
Iowa	Y	Y	N	Y
Kansas	N	N	N	N
Kentucky	Y	Y	Y	N
Louisiana	N	N	N	N
Maine	Y	N	N	Y
Maryland	Y	Y	N	Y
Massachusetts	Y	Y	N	Y
Michigan	Y	Y	Y	Y
Minnesota	Y	N	N	Y
Mississippi	Y	Y	N	N
Missouri	Y	N	Y	Y
Montana	Y	N	N	Y
Nebraska	Y	N	N	Y
Nevada	Y	Y	N	Y
New Hampshire	Y	Y	Y	N
New Jersey	Y	Y	N	N
New Mexico	N	N	N	N
New York	Y	Y	N	Y
North Carolina	Y	Y	Y	N
North Dakota	N	N	N	N
Ohio	Y	N	N	Y
Oklahoma	Y	N	N	Y
Oregon	Y	N	N	Y
Pennsylvania	Y	N	N	Y
Rhode Island	Y	Y	Y	N
South Carolina	Y	Y	N	N
South Dakota	N	N	N	N
Tennessee	N	N	N	N
Texas	Y	N	N	Y
Utah	N	Y	Y	N
Vermont	Y	Y	Y	Y
Virginia	N	N	N	N
Washington	Y	Y	N	N
West Virginia	Y	Y	Y	N
Wisconsin	Y	N	N	N
Wyoming	N	Y	Y	N

[1] Per spell of illness or admission.
[2] Coverage limits on all services and procedures.
[3] Prior authorization required for certain services and procedures.
[4] Per year.
[5] Per inpatient day.
[6] Per admission.

NOTE: Y is yes; N is no.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.9

Medicaid limits on prescribed drugs, by jurisdiction: March 1986

Medicaid jurisdiction[1]	Copayment amount	Number of prescriptions per month	Limits on number of refills	Number of days between refills	Limits on over-the-counter drugs	Limits on formulary legend drugs
Alabama	$0.50–$3.00		Y	34	Y	Y
Arkansas		4	Y	30	Y	N
California	1.00		N	100	Y	Y
Colorado	0.50		N	100	Y	Y
Connecticut			N	30	N	N
Delaware			N		Y	N
District of Columbia	0.50		Y	30	Y	N
Florida			N		Y	Y
Georgia		6	N	30	Y	Y
Hawaii			N	30	Y	Y
Idaho			N	34	Y	N
Illinois			N		Y	Y
Indiana			N		N	N
Iowa	1.00		N		Y	N
Kansas	1.00		N	100	N	Y
Kentucky			Y		Y	Y
Louisiana			Y	31	Y	N
Maine	0.50	5	Y	30	Y	N
Maryland			Y	100	Y	N
Massachusetts			N		Y	Y
Michigan	0.50		Y	120	Y	Y
Minnesota			Y	[2]30–100	Y	Y
Mississippi	1.00	4	Y		Y	Y
Missouri	0.50–2.00	5	Y	90	Y	Y
Montana	0.50		N		Y	N
Nebraska			N		N	Y
Nevada	1.00	3	Y	30	Y	N
New Hampshire	0.75		Y	90	N	Y
New Jersey			Y	60	N	N
New Mexico			Y		N	N
New York			Y		Y	Y
North Carolina	0.50	6	Y		Y	N
North Dakota			Y		N	N
Ohio			Y	34	Y	Y
Oklahoma		3	Y	34	Y	Y
Oregon		6	Y	30–90	Y	N
Pennsylvania	0.50		Y	34	N	N
Rhode Island			Y	30	Y	N
South Carolina	0.50	3	N	90	Y	N
South Dakota	1.00		N		Y	N
Tennessee		7	Y	31	Y	Y
Texas		3	Y	180	Y	Y
Utah			N		Y	N
Vermont	1.00		Y	30	Y	N
Virginia	0.50–1.00		N		Y	N
Washington			N	30	N	Y
West Virginia	0.50–1.00		Y	30	Y	Y
Wisconsin	0.50		Y	34	Y	N

[1] Alaska and Wyoming do not have drug programs.
[2] 30 days for acute problems and 100 days for maintenance problems.

NOTE: Y is yes; N is no.

SOURCE: Health Care Financing Adminsitration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Utilization

In this section, data are presented on the use of medical services by Medicaid recipients. The distribution of Medicaid recipients by type of medical service, number of recipients, and volume of services received is shown in the tables for general hospitals, SNF's, ICF's, physicians' services, and drug prescriptions. Recipient counts for each type of service are unduplicated, although recipients may have received more than one type of service. For example, the same recipient may have used inpatient hospital services, physicians' services, and outpatient hospital services. Thus, the total number of unduplicated recipients will generally be less than the sum of recipients who receive each service.

Medicaid recipient and service statistics are not presented as rates per 1,000 eligibles (population at risk), as are the Medicare data presented in Chapter 3. Instead, they represent average use by those who actually received services. (No national counts of Medicaid eligibles are available at present, although work is in progress to develop unduplicated counts of eligibles.) The number of recipients in each State Medicaid program in fiscal year 1985 and the percentage of total recipients who used specific services are shown in Table 4.10. Because a recipient can receive more than one service, the sum of individual percentages may exceed 100 percent.

In Table 4.11, the number and percent of Medicaid recipients and the percent of total vendor payments in fiscal year 1985 are displayed by type of medical service and recipient's age, sex, and race or ethnic origin. Persons under 21 years of age comprised 50.9 percent of total recipients. These individuals were proportionately high users of dental (61.6 percent) and other (57.3 percent) services. Recipients 21–64 years of age constituted 31.9 percent of all recipients and used proportionately more family planning services and laboratory and radiological services. Those 65 years of age or over used proportionately more SNF, ICF, and home health services. Females equaled or exceeded their proportion of the recipient population in the use of virtually every service.

Recipients under 21 years of age accounted for 19.1 percent of total Medicaid payments but 55.3 percent of all payments for dental services. Recipients 21–64 years of age accounted for 79.1 percent of all payments for family planning services, and those aged 65 or over accounted for 83.0 percent of SNF payments.

The number of recipients and total days of care in general hospitals, SNF's, and ICF's, along with the number of physician visits and the number of outpatient drug prescriptions for Medicaid recipients, are shown by jurisdiction for fiscal year 1985 in Table 4.12. For general hospitals, total discharges are a count of hospital stays, but recipients discharged are an unduplicated count of persons. A day of care in general hospitals, SNF's, or ICF's is counted only if paid for in whole or in part by Medicaid. As a result, it is not possible to derive average lengths of stay for Medicaid patients from these data alone.

A physician visit is a consultation with a physician or a person acting under the physician's supervision. When a physician's bill does not show visits but simply a flat fee, the recipient is reported as receiving physicians' services but the number of visits is not reported. The number of prescriptions includes refills but covers only drugs dispensed outside hospitals or other inpatient facilities.

Expenditures

In this section, the distribution of Medicaid vendor payments is described by maintenance assistance status, basis of eligibility, and type of service and by age, race or ethnicity, and sex of recipient. In Table 4.13, the distribution of vendor payments is presented by aid category and maintenance assistance status—cash assistance or medical assistance only. Cash assistance recipients accounted for 51.5 percent of total vendor payments; medical assistance recipients, for 48.5 percent. Except for the category 65 years of age or over, cash assistance recipients accounted for the larger share of vendor payments in each eligibility group.

Medicaid expenditures for fiscal year 1985 are displayed in Table 4.14 by rank of total payments for each jurisdiction and basis of eligibility. In fiscal year 1985, persons 65 years of age or over accounted for the largest share of total vendor payments (37.6 percent), although this group represented only 14.0 percent of all recipients (Table 4.5). The disabled also accounted for a disproportionate share of total vendor payments (35.2 percent of total vendor payments, as opposed to 13.5 percent of total recipients). In contrast, AFDC recipients, although representing 70.0 percent of all recipients, accounted for only 24.4 percent of total vendor payments.

New York and California combined accounted for 31.0 percent of all vendor payments in fiscal year 1985; the top six States accounted for 48.9 percent of the total. These six States (New York, California, Pennsylvania, Ohio, Illinois, and Michigan) also accounted for 45.6 percent of total recipients.

In Table 4.15, Medicaid programs are ranked by number of recipients and total vendor payments (shown in Tables 4.5 and 4.14, respectively). The two rankings are closely related. The most noticeable exception is Puerto Rico, which ranks third in number of recipients but only 40th in total vendor payments. This inconsistency reflects the congressionally mandated expenditure limit placed on Puerto Rico in 1972.

The distribution of vendor payments in each program is shown in Table 4.16 by age, sex, and race or ethnicity of those receiving services. Medicaid vendor payments by age varied widely across jurisdictions. Greater consistency existed with respect to sex, with females accounting for the larger share of total vendor payments in all jurisdictions.

The distribution of vendor payments across service categories in each Medicaid program is presented in Table 4.17. Among programs reporting for fiscal year 1985, 30.0 percent of all vendor payments went for services in ICF's, followed by services in inpatient hospitals (28.4 percent) and SNF's (13.5 percent).

In Table 4.18, average expenditure per Medicaid recipient, average per capita personal income, and percent of population below the U.S. poverty level (as defined by the Census Bureau) are reported for each State. Average expenditures per Medicaid recipient ranged from a low of $819 in West Virginia to a high of $3,384 in New York.

Table 4.10

Percent of Medicaid recipients, by type of service and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Number of recipients in thousands	Type of service: Inpatient hospital: General hospital	Inpatient hospital: Mental hospital	Skilled nursing facility	Intermediate care facility: Mentally retarded	Intermediate care facility: All other	Physicians'	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory and radiological	Home health	Prescribed drugs	Family planning	Other[1]
		Percent														
All jurisdictions	21,808.3	15.7	0.3	2.5	0.7	3.8	66.0	21.2	15.4	46.2	9.7	29.1	2.5	63.8	7.5	24.6
Alabama	316.2	18.4	0.1	1.1	0.5	5.5	78.3	13.8	11.0	29.1	1.9	36.7	1.9	72.2	7.9	23.1
Alaska	24.0	12.4	2.7	1.4	0.5	1.8	66.0	20.2	16.6	32.2	18.0	1.6	0.2	0.0	5.8	24.8
Arkansas	197.3	23.8	0.0	3.0	0.7	8.3	82.6	17.4	14.0	40.3	4.2	6.7	1.8	80.5	5.4	21.9
California	3,380.7	14.0	0.0	3.5	0.3	0.4	71.5	27.3	16.5	39.9	9.0	49.3	0.5	65.5	7.0	26.6
Colorado	147.3	14.7	1.1	3.5	1.1	6.6	54.4	18.8	24.9	44.9	40.3	24.2	5.2	68.1	8.1	25.9
Connecticut	217.4	18.2	0.6	5.9	0.6	8.4	65.7	33.5	26.3	53.7	15.4	17.0	2.8	71.1	8.9	24.7
Delaware	40.6	14.6	0.2	0.7	1.1	4.4	76.5	13.1	8.7	49.4	4.4	8.9	1.8	72.6	12.8	6.9
District of Columbia	98.3	19.5	0.7	0.4	0.6	2.8	74.0	10.7	5.6	52.8	8.5	23.6	2.7	65.1	7.5	23.0
Florida	561.9	11.6	0.0	1.7	0.6	5.0	70.7	15.1	11.3	20.8	2.7	38.4	6.3	74.6	5.0	89.7
Georgia	468.9	20.7	0.0	3.0	0.4	4.7	77.4	20.7	8.3	47.6	4.2	8.7	2.2	78.6	8.6	24.4
Hawaii	92.2	13.7	0.0	2.0	0.3	2.4	82.0	41.3	7.9	30.7	5.3	30.3	0.5	73.9	6.7	10.9
Idaho	38.8	15.2	0.0	4.3	1.3	6.4	78.7	18.2	12.2	39.9	6.1	50.9	1.7	72.0	7.5	20.2
Illinois	1,063.4	18.5	0.2	1.9	0.8	5.0	74.1	4.2	14.3	38.6	11.6	35.2	1.7	72.9	10.6	20.6
Indiana	284.0	21.3	0.1	3.9	0.8	10.4	80.9	34.1	29.3	48.2	21.2	9.0	0.8	75.7	5.9	27.4
Iowa	211.9	14.7	0.2	0.1	0.9	9.4	81.3	41.0	25.6	39.8	3.0	10.1	2.0	73.5	11.0	17.0
Kansas	141.7	17.4	0.7	0.5	1.6	10.3	79.5	26.0	12.7	34.3	10.3	21.1	1.7	67.5	7.6	21.3
Kentucky	408.2	18.8	0.2	1.7	0.3	4.1	82.2	21.3	10.7	43.6	11.0	7.1	3.1	69.8	8.8	10.0
Louisiana	416.2	20.4	0.2	0.2	1.4	7.0	49.7	12.6	20.8	43.5	3.7	72.8	1.0	75.4	9.4	31.0
Maine	124.4	22.6	0.0	0.6	0.6	7.1	79.6	23.6	22.1	57.7	5.0	5.3	3.4	72.3	8.9	15.0
Maryland	328.8	20.6	0.2	0.8	0.6	7.3	74.6	22.0	18.2	48.3	5.0	21.7	1.6	71.4	11.2	12.4
Massachusetts	522.9	20.6	0.0	3.6	0.7	4.9	66.9	29.1	22.8	52.3	16.6	17.2	4.4	69.3	8.1	37.1
Michigan	1,133.3	12.1	0.3	1.6	0.3	3.3	72.0	24.7	14.6	36.6	2.0	19.8	0.8	63.8	12.0	26.1
Minnesota	357.3	14.7	0.3	8.1	2.2	5.0	77.4	38.2	9.0	33.7	6.2	7.1	4.0	66.2	8.3	36.1
Mississippi	299.7	20.4	0.0	2.4	0.5	2.9	82.4	23.9	4.4	36.0	0.0	10.7	1.0	79.5	9.8	26.3
Missouri	356.0	18.7	0.2	1.0	1.3	7.2	63.6	28.2	15.3	45.8	30.8	18.8	1.4	70.0	10.0	12.1
Montana	47.3	17.1	0.0	0.7	0.6	9.9	80.2	35.0	25.2	37.4	4.1	7.5	1.1	65.9	7.2	18.7
Nebraska	93.9	18.1	0.4	1.4	1.0	9.6	79.7	31.4	28.0	35.6	2.0	30.9	1.3	72.7	7.0	23.3
Nevada	28.2	16.5	0.1	1.9	0.7	8.2	69.2	18.8	8.3	35.5	3.0	20.8	3.2	65.6	6.5	46.8
New Hampshire	37.7	16.8	0.5	0.4	1.0	14.5	54.8	21.0	19.6	39.9	9.8	8.8	4.0	70.7	7.6	20.8
New Jersey	581.4	14.6	0.3	0.9	0.7	4.7	74.3	31.5	21.2	44.8	8.7	32.4	1.5	81.7	8.7	17.8
New Mexico	87.3	19.9	0.0	0.3	0.7	4.7	75.7	27.4	6.4	42.8	8.2	11.5	1.5	72.5	7.6	33.0
New York	2,242.1	14.5	1.0	3.8	0.8	1.1	65.0	21.7	24.8	50.1	20.5	43.9	10.1	59.3	8.7	24.8
North Carolina	343.2	21.2	0.4	4.2	0.9	3.8	69.9	25.7	12.2	42.5	6.8	45.3	1.8	70.1	6.4	19.3
North Dakota	36.7	26.5	0.6	8.8	1.8	7.9	73.9	34.2	21.0	26.2	4.3	16.4	3.3	62.4	6.6	20.3
Ohio	1,045.1	16.9	0.1	3.5	0.7	2.5	75.5	29.4	23.2	54.4	11.6	12.6	0.8	71.7	2.6	22.7

See footnotes at end of table.

Table 4.10—Continued

Percent of Medicaid recipients, by type of service and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Number of recipients in thousands	Type of service														
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory and radiological	Home health	Prescribed drugs	Family planning	Other[1]
		General hospital	Mental hospital		Mentally retarded	All other										
		Percent														
Oklahoma	270.0	17.3	0.5	0.0	0.9	8.6	61.6	10.6	3.7	9.7	0.8	1.3	0.0	47.3	2.0	23.3
Oregon	152.5	14.4	0.3	0.7	1.2	7.3	66.8	14.9	8.5	36.0	5.0	45.2	3.1	68.0	8.0	44.7
Pennsylvania	1,071.0	16.2	0.5	1.8	0.8	5.0	55.9	29.6	12.8	50.0	13.9	28.9	1.0	68.2	9.1	22.6
Puerto Rico	1,571.9	4.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	100.8	15.1	0.1	0.9	1.2	9.7	65.2	27.1	17.7	44.0	0.0	13.3	1.5	73.9	5.5	32.0
South Carolina	237.6	26.5	0.6	2.4	1.0	2.9	73.2	17.6	1.6	41.2	3.2	6.5	1.4	71.1	8.3	28.0
South Dakota	33.8	23.2	0.4	1.0	2.2	15.1	72.9	18.5	8.6	36.4	6.4	36.8	3.6	60.5	5.2	24.3
Tennessee	362.1	24.7	0.7	1.4	0.8	7.4	72.0	13.9	6.2	30.6	15.4	34.7	2.0	75.1	6.9	22.3
Texas	761.3	20.7	0.0	0.9	1.7	9.5	83.3	6.1	22.3	33.8	0.0	33.0	4.2	79.7	6.4	25.1
Utah	72.2	15.0	0.2	1.5	1.9	6.3	78.9	26.0	14.2	35.6	1.4	7.4	0.6	65.8	0.4	7.5
Vermont	50.4	15.1	0.1	1.0	0.6	5.8	81.4	21.8	17.7	39.7	9.1	5.6	4.4	73.6	9.6	22.2
Virgin Islands	16.6	7.1	0.0	0.0	0.0	0.0	0.4	12.2	0.0	93.2	0.0	0.3	0.1	52.4	5.0	9.9
Virginia	303.0	18.5	0.3	0.8	1.1	6.1	80.2	16.3	7.2	48.9	12.1	33.3	1.4	73.6	11.5	25.9
Washington	326.4	12.7	0.2	6.5	0.9	0.4	82.2	21.4	22.7	41.7	0.0	47.0	1.3	70.4	13.2	31.6
West Virginia	211.4	16.3	0.0	1.4	0.1	2.1	78.3	16.5	10.4	35.6	6.0	14.6	0.4	62.4	7.3	36.6
Wisconsin	473.3	12.6	0.3	7.7	0.5	4.8	55.4	30.8	14.1	41.2	36.4	51.0	1.8	63.8	9.9	37.8
Wyoming	19.5	15.0	0.1	2.0	0.0	9.2	82.2	16.6	13.9	35.8	0.0	11.6	0.2	0.0	4.3	9.0

[1] Includes early and periodic screening, diagnosis, and treatment services; rural health care; and other services.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.11

Percent of Medicaid recipients and payments, by age, sex, race or ethnic origin, and type of service: Fiscal year 1985

Type of service	Number of recipients in thousands	Age				Sex		Race or ethnic origin[1]				
		Under 6 years	6–20 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
						Percent of recipients						
All services	21,808	21.7	29.2	31.9	17.1	35.9	64.1	57.3	31.3	0.8	1.9	8.7
Inpatient hospital	3,494	16.9	17.4	39.6	26.1	30.4	69.6	61.0	30.1	0.8	1.2	6.9
Skilled nursing facility	547	1.0	1.1	12.7	85.1	27.8	72.2	89.1	8.9	0.2	0.7	1.2
Intermediate care facility[2]	975	0.6	3.5	22.0	73.8	31.9	68.1	87.8	10.9	0.3	0.4	1.2
Physicians'	14,387	22.4	27.0	33.2	17.4	34.7	65.3	58.7	30.4	0.7	2.0	8.2
Dental	4,634	15.8	45.8	31.3	7.1	37.2	62.8	59.1	29.0	0.8	2.5	8.6
Other practitioners'	3,357	7.9	30.6	38.7	22.8	30.8	69.2	63.9	27.3	0.7	1.3	6.9
Outpatient hospital	10,072	23.3	27.5	37.5	11.6	35.2	64.8	55.2	33.3	0.7	1.3	9.5
Clinic	2,121	22.7	28.2	40.4	8.7	36.0	64.0	54.2	34.4	0.9	1.9	8.6
Laboratory and radiological	6,354	16.9	25.0	42.6	15.5	29.6	70.4	54.6	32.4	0.6	2.3	10.0
Home health	535	9.8	6.0	36.2	48.1	28.7	71.3	66.8	26.7	0.4	2.1	4.0
Prescribed drugs	13,921	21.0	24.8	34.7	19.6	33.4	66.6	58.5	31.0	0.6	1.9	8.0
Family planning	1,636	0.0	33.3	66.7	0.0	1.8	98.2	49.4	41.0	0.6	1.1	7.9
Other	5,370	31.7	25.6	21.7	21.0	38.5	61.5	56.6	33.1	1.0	1.9	7.3
	Payments in millions					Percent of payments						
All services	$37,507.6	7.5	11.6	40.1	40.8	34.6	65.4	72.8	21.8	0.5	1.0	3.9
Inpatient hospital	10,645.1	14.6	16.4	43.6	25.5	37.6	62.4	60.3	31.6	0.7	1.2	6.2
Skilled nursing facility	5,072.5	0.9	1.8	14.3	83.0	25.2	74.8	90.0	8.0	0.2	0.8	1.0
Intermediate care facility[2]	11,244.6	0.4	6.6	40.9	52.0	39.1	60.9	86.5	11.8	0.3	0.5	1.0
Physicians'	2,345.6	16.4	20.0	50.4	13.2	30.1	69.9	60.0	28.8	0.8	2.1	8.3
Dental	457.9	11.7	43.6	37.0	7.6	35.1	64.9	59.0	28.1	0.9	2.9	9.0
Other practitioners'	251.1	7.6	26.9	47.5	18.0	33.1	66.9	68.1	23.9	0.8	1.2	6.0
Outpatient hospital	1,789.1	18.1	22.7	51.3	8.0	34.2	65.8	54.6	36.0	0.7	1.1	7.6
Clinic	714.2	9.7	20.1	61.6	8.7	41.4	58.6	63.6	30.0	0.4	1.0	5.0
Laboratory and radiological	337.2	10.2	19.7	61.4	8.8	25.7	74.3	51.0	36.7	0.7	2.1	9.6
Home health	1,119.7	2.8	3.5	39.6	54.1	28.0	72.0	68.6	26.6	0.3	0.6	3.9
Prescribed drugs	2,315.5	5.4	7.6	43.0	44.0	27.9	72.1	70.1	24.6	0.3	1.3	3.8
Family planning	195.2	0.0	20.9	79.1	0.0	1.7	98.3	48.7	41.0	0.6	1.2	8.5
Other	1,019.9	12.9	17.5	42.6	27.0	39.7	60.3	64.7	28.8	1.3	1.4	3.8

[1] The race or ethnic origin of significant numbers of recipients in some reporting States are unknown. The Office of the Actuary estimated recipients and payments by race or ethnic origin for these States. Data by race or ethnic origin, therefore, should be used with caution.

[2] Figures include intermediate care facilities (ICF's) for the mentally retarded and all other ICF's. Recipients and expenditures within the category 21–64 years reflect mainly use of ICF's for the mentally retarded. Recipients and expenditures within the age category 65 years or over reflect mainly use of all other ICF's.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.12

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal year 1985

Medicaid jurisdiction	General hospital			SNF[1]		ICF[2] (other than mentally retarded)		ICFMR[3]		Physician visits	Rural health visits	Home health visits	Number of drug prescriptions
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care				
All jurisdictions	3,615,720	2,389,761	29,562,235	546,627	111,670,812	828,945	207,098,068	146,001	47,056,928	76,470,052	278,469	14,507,600	190,126,477
Alabama	47,196	34,986	191,719	3,386	383,634	17,355	4,713,511	1,468	505,041	635,357	3,876	141,380	3,303,229
Alaska	1,907	1,417	41,513	333	32,825	427	58,567	125	3,671	61,312	955	468	0
Arkansas	33,116	25,103	188,486	5,849	1,158,434	16,305	4,159,403	1,452	461,173	711,992	0	15,399	1,556,114
California	444,580	332,880	2,837,040	119,260	23,231,400	12,080	1,136,580	9,740	3,007,960	9,272,260	260	129,320	20,884,600
Colorado	31,309	14,250	138,350	5,123	1,009,472	9,686	2,536,045	1,574	567,876	496,003	0	2,311,268	1,470,673
Connecticut	74,503	36,822	338,918	12,927	821,260	18,159	5,060,194	1,309	393,969	467,401	37	1,038,144	2,492,792
Delaware	6,404	5,049	29,765	273	41,000	1,805	501,760	442	150,619	212,041	0	0	292,231
District of Columbia	22,232	15,763	208,016	383	46,672	2,762	726,069	561	171,454	839,332	0	564,461	751,157
Florida	47,911	39,310	313,177	9,783	1,053,962	27,927	5,352,118	3,221	946,271	1,257,384	10,485	52,070	6,761,202
Georgia	76,059	55,000	442,018	13,988	3,058,440	21,909	6,575,805	1,750	616,000	1,134,195	10,407	414,614	6,310,297
Hawaii	14,310	10,489	77,775	1,873	244,418	2,191	557,068	263	84,832	414,880	0	8,084	728,475
Idaho	6,421	4,477	30,291	1,663	261,305	2,494	653,608	509	182,210	115,446	1,279	7,820	276,867
Illinois	227,472	158,305	1,415,872	20,429	4,047,795	52,938	14,187,547	8,546	2,789,386	4,632,688	0	261,585	11,711,566
Indiana	75,136	46,626	405,103	10,981	2,857,441	29,580	9,603,867	2,195	660,683	1,192,291	0	0	3,481,850
Iowa	33,568	24,455	176,650	304	30,242	19,832	5,567,811	1,856	625,259	842,299	2,340	0	2,106,811
Kansas	49,977	21,809	272,152	768	96,790	14,654	4,376,654	2,280	813,045	368,288	10	17,838	1,476,261
Kentucky	86,821	—	414,066	6,742	813,986	16,795	4,256,559	1,264	434,882	2,451,925	17,017	489,514	3,632,097
Louisiana	76,287	57,231	385,965	733	133,040	28,931	7,993,596	5,710	1,940,804	263,095	0	86,407	5,270,165
Maine	30,520	22,346	108,218	687	64,424	8,862	2,415,885	709	254,372	447,990	22,846	90,066	1,211,467
Maryland	56,679	40,272	321,285	2,776	182,045	24,019	4,982,590	1,865	411,524	1,025,867	2,178	67,747	2,612,250
Massachusetts	127,552	55,329	2,116,500	18,581	4,117,125	25,436	6,957,367	3,533	1,118,639	305,429	0	1,214,182	4,694,015
Michigan	153,534	115,390	972,226	18,304	2,682,465	37,470	9,123,609	3,670	1,207,160	8,573,229	0	138,264	9,577,557
Minnesota	68,222	49,975	448,907	29,097	6,779,330	17,755	3,911,930	7,808	2,791,041	1,861,936	0	58,835	3,751,075
Mississippi	44,726	33,359	173,184	7,132	1,684,320	8,598	2,192,487	1,648	520,578	727,428	13,247	37,966	2,906,379
Missouri	75,136	51,701	416,060	3,468	247,743	25,701	6,694,805	4,698	543,807	3,498,370	0	113,030	3,505,487
Montana	9,894	6,264	48,485	346	36,054	4,666	1,222,931	284	85,721	160,717	0	8,345	465,723
Nebraska	16,699	11,960	75,480	1,309	218,498	9,004	2,480,147	894	306,951	719,263	0	12,272	1,154,804
Nevada	4,919	3,044	30,146	527	43,767	2,312	549,432	205	66,491	0	0	0	0
New Hampshire	5,808	4,146	32,732	143	11,125	5,478	1,543,793	374	143,410	164,688	673	262,196	478,087
New Jersey	102,883	66,008	747,623	4,978	686,014	27,225	7,397,140	4,027	1,359,869	2,386,736	0	575,447	6,442,005
New Mexico	18,327	12,762	80,745	261	27,662	4,144	1,046,314	624	200,693	284,573	7,686	36,971	835,553
New York	475,740	297,720	10,386,580	84,875	23,167,203	25,558	6,987,980	17,255	5,619,656	10,328,382	0	3,776,242	25,595,532
North Carolina	62,355	44,257	391,125	14,438	2,564,036	12,944	3,306,788	3,083	994,348	820,006	27,843	45,660	3,248,392
North Dakota	15,177	7,914	58,027	3,241	706,765	2,882	684,691	649	187,210	111,900	0	228,537	461,067
Ohio	189,483	144,596	1,013,354	37,098	9,675,523	25,848	7,476,106	7,442	2,566,928	2,573,838	43,611	125,745	10,436,512

See footnotes at end of table.

Table 4.12—Continued

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal year 1985

Medicaid jurisdiction	General hospital			SNF[1]		ICF[2] (other than mentally retarded)		ICFMR[3]		Physician visits	Rural health visits	Home health visits	Number of drug prescriptions
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care				
Oklahoma	67,518	46,720	402,714	107	28,125	23,216	6,159,059	2,456	705,447	1,274,118	0	607	1,222,547
Oregon	37,849	20,931	177,339	1,130	96,760	11,086	2,740,795	1,856	634,692	357,682	1,013	63,594	1,530,955
Pennsylvania	166,375	126,855	891,160	19,149	2,972,871	53,983	5,192,653	8,317	2,887,340	3,147,043	34,923	211,382	10,399,651
Puerto Rico	—	—	—	—	—	—	—	0	0	0	0	0	0
Rhode Island	15,173	14,068	235,966	880	89,332	9,739	2,354,043	1,164	384,119	277,427	3,071	23,887	979,932
South Carolina	51,777	33,096	157,758	5,605	1,299,490	6,859	1,969,632	2,487	858,523	286,462	183	93,773	1,437,361
South Dakota	7,724	5,212	73,084	349	57,668	5,110	1,401,703	748	248,366	99,069	7,197	202,796	311,423
Tennessee	36,222	30,172	167 662	5,091	535,301	26,733	6,784,277	2,762	872,122	1,606,793	808	134,465	4,847,161
Texas	131,987	98,590	646,694	7,224	1,130,647	72,354	20,043,308	12,807	4,314,783	4,946,501	0	33,000	6,697,299
Utah	9,211	9,063	57,135	1,086	46,632	4,559	1,048,380	1,386	436,867	430,955	1,141	15,112	581,549
Vermont	10,849	7,024	62,534	507	15,542	2,902	744,244	282	98,320	433,037	9,559	164,859	504,499
Virgin Islands	1,419	1,143	7,957	0	0	0	0	0	0	352	0	54	25,123
Virginia	51,824	38,824	279,321	2,291	298,683	18,590	4,957,506	3,220	1,150,828	1,053,020	0	105,434	3,769,920
Washington	60,416	35,892	270,818	21,209	5,366,904	1,190	297,368	2,841	920,336	1,323,969	2,325	127,293	2,695,279
West Virginia	36,606	27,293	147,694	3,005	709,043	4,403	1,124,916	258	64,301	1,191,726	52,933	28,433	1,219,128
Wisconsin	114,523	41,487	642,180	36,550	6,749,381	22,683	4,898,851	2,384	747,351	667,490	566	972,951	4,022,358
Wyoming	3,384	2,376	14,666	385	58,218	1,806	390,576	0	0	15,867	0	83	0

[1] Skilled nursing facility.
[2] Intermediate care facility.
[3] Intermediate care facility for the mentally retarded.

NOTE: Data are unedited raw data.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.13

Amount and percent distribution of Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal year 1985

Basis of eligibility	Total payments in millions	Maintenance assistance status		
		Total	Cash assistance	Medical assistance only
		Percent distribution		
Total	$37,507.6	100.0	51.5	48.5
Age 65 or over	14,096.3	100.0	24.9	75.1
Blind	249.4	100.0	69.4	30.6
Disabled	13,202.8	100.0	60.9	39.1
Dependent children under age 21	4,414.3	100.0	82.5	17.5
Adults in families with dependent children	4,746.4	100.0	83.4	16.6
Other title XIX	798.4	100.0	NA	100.0

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.14

Amount and percent of Medicaid payments, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1985

Medicaid jurisdiction	Payments in millions	Percent of total	Cumulative percent of total	Basis of eligibility				
				Age 65 or over	Blind	Disabled	AFDC[1]	Other title XIX
						Percent		
All jurisdictions	$37,507.6	100.0	100.0	37.6	0.7	35.2	24.4	2.1
New York	7,588.0	20.2	20.2	49.8	0.7	31.6	16.2	1.7
California	4,045.3	10.8	31.0	22.5	1.2	37.6	34.6	4.2
Pennsylvania	1,797.4	4.8	35.8	38.8	0.2	34.0	24.9	2.1
Ohio	1,767.4	4.7	40.5	30.1	0.3	32.9	36.7	0.0
Illinois	1,652.9	4.4	44.9	20.2	0.3	46.5	32.6	0.4
Michigan	1,516.6	4.0	48.9	25.3	0.4	36.4	33.9	4.0
Massachusetts	1,432.6	3.8	52.7	43.4	2.1	35.4	16.2	2.9
Texas	1,413.9	3.8	56.5	43.7	0.7	35.9	19.6	0.1
New Jersey	1,144.7	3.1	59.6	36.1	0.3	33.3	27.0	3.3
Minnesota	1,001.1	2.7	62.3	43.4	0.5	37.1	15.2	3.8
Florida	943.1	2.5	64.8	43.9	0.5	34.6	20.3	0.7
Wisconsin	942.2	2.5	67.3	41.9	0.5	36.1	20.9	0.6
Georgia	759.6	2.0	69.3	32.5	0.9	40.4	26.1	0.1
Indiana	746.7	2.0	71.3	36.4	0.5	37.7	25.4	0.0
Louisiana	725.3	1.9	73.2	34.1	0.7	40.8	23.6	0.9
North Carolina	646.7	1.7	74.9	38.1	0.9	34.8	22.3	3.9
Connecticut	594.9	1.6	76.5	49.8	0.2	27.0	18.0	5.0
Washington	584.1	1.6	78.1	31.6	0.2	38.0	30.1	0.1
Maryland	583.9	1.6	79.7	39.0	0.2	27.6	32.5	0.7
Tennessee	577.8	1.5	81.2	36.1	0.7	36.9	22.7	3.5
Virginia	546.9	1.5	82.7	43.4	0.5	36.5	18.4	1.2
Kentucky	539.8	1.4	84.1	30.2	0.7	37.7	29.8	1.7
Missouri	524.9	1.4	85.5	42.9	0.7	32.6	23.4	0.5
Oklahoma	460.4	1.2	86.7	41.2	0.2	24.3	32.6	1.7
Alabama	375.4	1.0	87.7	39.5	0.6	38.8	20.7	0.4
Iowa	359.9	1.0	88.7	31.2	0.5	32.6	30.7	5.1
Arkansas	358.3	1.0	89.7	38.1	1.0	41.3	14.9	4.8
Colorado	315.8	0.8	90.5	32.1	1.0	44.9	22.0	0.0
South Carolina	309.4	0.8	91.3	35.8	0.9	42.1	21.2	0.1
District of Columbia	297.7	0.8	92.1	30.9	0.1	38.8	27.0	3.1

See footnotes at end of table.

Table 4.14—Continued

Amount and percent of Medicaid payments, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1985

Medicaid jurisdiction	Payments in millions	Percent of total	Cumulative percent of total	Basis of eligibility				
				Age 65 or over	Blind	Disabled	AFDC[1]	Other title XIX
				Percent				
Mississippi	274.4	0.7	92.8	41.6	0.7	33.0	24.6	0.1
Kansas	256.3	0.7	93.5	35.4	0.3	35.7	24.1	4.5
Rhode Island	250.0	0.7	94.2	47.1	0.5	40.1	12.1	0.2
Oregon	238.7	0.6	94.8	33.8	2.7	36.9	25.1	1.5
Maine	232.4	0.6	95.4	45.4	0.2	32.1	22.3	0.1
West Virginia	173.2	0.5	95.9	39.0	0.3	25.1	35.0	0.6
Nebraska	167.1	0.4	96.3	42.1	0.5	31.5	22.1	3.8
New Mexico	148.3	0.4	96.7	27.2	1.4	43.8	27.6	0.0
Hawaii	140.4	0.4	97.1	43.0	0.3	24.0	32.3	0.4
Puerto Rico	139.1	0.4	97.5	0.0	0.1	4.7	56.7	38.4
New Hampshire	118.0	0.3	97.8	53.6	1.9	34.2	10.1	0.2
North Dakota	116.7	0.3	98.1	47.4	0.1	31.4	15.5	5.7
Utah	109.7	0.3	98.4	25.5	0.2	41.6	27.3	5.4
Montana	95.5	0.3	98.7	40.4	0.3	35.3	24.0	0.0
South Dakota	94.4	0.3	99.0	42.7	0.4	41.8	14.1	1.0
Vermont	89.4	0.2	99.2	37.6	0.2	40.0	21.4	0.9
Idaho	76.3	0.2	99.4	37.1	0.2	41.4	20.4	0.9
Delaware	70.5	0.2	99.6	39.9	0.4	32.3	26.0	1.4
Alaska	66.5	0.2	99.8	25.8	0.4	37.9	22.8	13.0
Nevada	65.7	0.2	100.0	35.0	1.9	43.1	17.7	2.2
Wyoming	28.2	0.1	100.0	53.2	0.3	14.2	32.1	0.1
Virgin Islands	4.1	0.0	100.0	17.8	0.0	6.8	69.5	5.9

[1] Aid to Families with Dependent Chiildren.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.15

Medicaid jurisdictions ranked by number of recipients and payments for recipients: Fiscal year 1985

Medicaid jurisdiction	Number of recipients	Amount of payments	Medicaid jurisdiction	Number of recipients	Amount of payments
	Rank order			Rank order	
California	1	2	South Carolina	27	29
New York	2	1	Connecticut	28	17
Puerto Rico	3	40	Iowa	29	26
Michigan	4	6	West Virginia	30	36
Pennsylvania	5	3	Arkansas	31	27
Illinois	6	5	Oregon	32	34
Ohio	7	4	Colorado	33	28
Texas	8	8	Kansas	34	32
New Jersey	9	9	Maine	35	35
Florida	10	11	Rhode Island	36	33
Massachusetts	11	7	District of Columbia	37	30
Wisconsin	12	12	Nebraska	38	37
Georgia	13	13	Hawaii	39	39
Louisiana	14	15	New Mexico	40	38
Kentucky	15	22	Utah	41	43
Tennessee	16	20	Vermont	42	46
Minnesota	17	10	Montana	43	44
Missouri	18	23	Delaware	44	48
North Carolina	19	16	Idaho	45	47
Maryland	20	19	New Hampshire	46	41
Washington	21	18	North Dakota	47	42
Alabama	22	25	South Dakota	48	45
Virginia	23	21	Nevada	49	50
Mississippi	24	31	Alaska	50	49
Indiana	25	14	Wyoming	51	51
Oklahoma	26	24	Virgin Islands	52	52

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.16

Average Medicaid payment per recipient, by jurisdiction, and percent of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin[1]				
			Under 21 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
						Percent						
All jurisdictions	$37,507.6	$1,720	19.1	40.1	40.8	34.6	65.4	72.8	21.8	0.5	1.0	3.9
Alabama	375.4	1,187	16.1	39.7	44.2	30.7	69.3	59.3	40.7	0.0	0.0	0.0
Alaska	66.5	2,768	40.7	33.1	26.2	34.9	65.1	57.0	5.9	34.6	1.7	0.8
Arkansas	358.3	1,816	21.0	33.7	45.3	35.8	64.2	70.6	29.3	0.0	0.1	0.0
California	4,045.3	1,197	24.6	49.0	26.4	36.7	63.3	64.0	16.0	0.3	3.8	15.8
Colorado	315.8	2,144	17.3	43.0	39.7	38.6	61.4	75.4	5.7	0.4	0.4	18.1
Connecticut	594.9	2,736	15.9	35.3	48.8	33.2	66.8	85.3	14.7	0.0	0.0	0.0
Delaware	70.5	1,738	20.2	39.5	40.4	32.3	67.7	60.3	37.1	0.1	0.2	2.4
District of Columbia	297.7	3,029	16.1	38.0	46.0	37.1	62.9	10.9	89.1	0.0	0.0	0.0
Florida	943.1	1,678	16.1	34.8	49.1	29.9	70.1	65.4	27.4	0.0	5.6	1.6
Georgia	759.6	1,620	21.0	41.0	38.0	29.7	70.3	53.8	46.0	0.0	0.1	0.1
Hawaii	140.4	1,522	19.4	37.5	43.1	37.2	62.8	25.4	0.5	0.0	73.0	1.1
Idaho	76.3	1,965	19.9	42.2	37.9	35.3	64.7	94.4	0.4	2.1	0.4	2.8
Illinois	1,652.9	1,554	22.3	51.3	26.4	36.3	63.7	57.3	36.9	0.1	0.6	5.1
Indiana	746.7	2,630	17.4	41.3	41.2	31.3	68.7	80.8	17.9	0.0	0.2	1.0
Iowa	359.9	1,698	21.5	43.3	35.1	35.2	64.8	94.4	4.3	0.3	0.5	0.4
Kansas	256.3	1,809	25.3	39.6	35.1	36.7	63.3	84.9	12.8	0.5	0.0	1.7
Kentucky	539.8	1,322	24.1	43.8	32.1	33.6	66.4	98.4	1.6	0.0	0.0	0.0
Louisiana	725.3	1,743	23.7	41.4	35.0	35.6	64.4	51.8	48.2	0.0	0.0	0.0
Maine	232.4	1,868	13.6	38.2	48.2	33.7	66.3	—	—	—	—	—
Maryland	583.9	1,776	21.0	38.1	40.9	31.8	68.2	56.0	43.0	0.1	0.6	0.4
Massachusetts	1,432.6	2,739	14.4	39.3	46.3	33.9	66.1	88.4	7.7	0.1	0.4	3.5
Michigan	1,516.6	1,338	24.6	47.9	27.6	34.7	65.3	68.6	29.8	0.2	0.4	1.0
Minnesota	1,001.1	2,802	15.3	36.4	48.3	35.8	64.2	94.4	2.3	1.7	1.3	0.3
Mississippi	274.4	916	18.3	33.8	48.0	30.0	70.0	44.7	55.2	0.1	0.1	0.0
Missouri	524.9	1,474	13.6	34.9	51.6	30.7	69.3	77.7	22.0	0.1	0.0	0.1
Montana	95.5	2,019	15.1	40.0	44.9	33.4	66.6	90.1	0.0	8.8	0.2	0.8
Nebraska	167.1	1,779	20.2	37.6	42.3	35.1	64.9	86.2	9.8	2.0	0.4	1.5
Nevada	65.7	2,328	20.0	43.3	36.7	35.9	64.1	81.2	13.3	1.8	0.8	2.9
New Hampshire	118.0	3,129	6.7	38.4	54.9	32.0	68.0	—	—	—	—	—
New Jersey	1,144.7	1,969	19.8	40.7	39.5	32.7	67.3	64.9	27.2	0.1	0.1	7.7
New Mexico	148.3	1,698	22.6	45.3	32.1	36.9	63.1	93.1	4.1	2.7	0.0	0.0
New York	7,588.0	3,384	15.0	33.3	51.7	34.4	65.6	76.7	20.4	0.1	0.1	2.7
North Carolina	646.7	1,884	18.6	42.3	39.0	34.5	65.5	59.3	39.1	1.4	0.1	0.1
North Dakota	116.7	3,183	14.5	37.8	47.7	36.6	63.4	89.7	0.2	9.7	0.1	0.3
Ohio	1,767.4	1,691	25.0	41.9	33.1	33.3	66.7	75.4	23.5	0.2	0.1	0.7

See footnotes at end of table.

Table 4.16—Continued

Average Medicaid payment per recipient, by jurisdiction, and percent of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin[1]				
			Under 21 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
								Percent				
Oklahoma	$460.4	$1,706	24.0	36.3	39.7	33.9	66.1	80.3	13.6	5.0	0.3	0.8
Oregon	238.7	1,565	19.9	44.6	35.5	34.2	65.8	92.1	4.3	1.4	1.1	1.2
Pennsylvania	1,797.4	1,678	20.1	40.1	39.9	35.9	64.1	76.9	20.3	0.0	0.3	2.5
Puerto Rico	139.1	89	44.5	54.5	1.0	40.2	59.8	—	—	—	—	—
Rhode Island	250.0	2,482	11.2	32.3	56.4	30.4	69.6	82.8	11.1	0.1	1.5	4.6
South Carolina	309.4	1,302	18.7	40.5	40.8	32.4	67.6	54.3	45.7	0.0	0.0	0.0
South Dakota	94.4	2,790	18.5	36.5	45.1	37.9	62.1	85.8	0.1	14.1	0.0	0.0
Tennessee	577.8	1,596	33.2	38.4	28.4	32.2	67.8	71.3	28.6	0.0	0.1	0.0
Texas	1,413.9	1,857	17.1	38.7	44.2	32.9	67.1	63.1	20.8	0.1	0.3	15.7
Utah	109.7	1,519	27.2	46.7	26.1	39.6	60.4	91.8	0.1	1.9	0.8	5.4
Vermont	89.4	1,775	16.9	43.6	39.5	35.0	65.0	99.2	0.1	0.1	0.6	0.0
Virgin Islands	4.1	249	41.2	40.9	17.8	29.1	70.9	—	—	—	—	—
Virginia	546.9	1,805	15.4	37.6	46.9	33.8	66.2	61.6	37.5	0.0	0.5	0.3
Washington	584.1	1,789	19.5	48.4	32.1	34.5	65.5	89.6	4.6	2.5	1.2	2.1
West Virginia	173.2	819	20.1	40.0	39.9	29.3	70.7	95.4	4.6	0.0	0.0	0.0
Wisconsin	942.2	1,991	17.7	37.4	44.9	35.7	64.3	89.0	8.0	1.2	0.5	1.3
Wyoming	28.2	1,444	19.8	20.9	59.3	28.5	71.5	92.3	1.3	1.0	0.0	5.4

[1] The race or ethnic origin of significant numbers of recipients in some reporting States was unknown. The Office of the Actuary estimated payments by race or ethnic origin for these States. Data by race or ethnic origin, therefore, should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.17

Percent of Medicaid payments, by type of service and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Total payments in millions	Type of service						
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental
		General hospital	Mental hospital		Mentally retarded	All other		
		Percent						
All jurisdictions	$37,507.6	25.2	3.2	13.5	12.6	17.4	6.3	1.2
Alabama	375.4	19.7	0.5	2.8	13.1	32.8	9.7	1.1
Alaska	66.5	26.3	2.1	7.0	15.3	19.4	14.1	2.1
Arkansas	358.3	20.8	0.1	9.7	11.8	28.5	8.4	1.1
California	4,045.3	37.3	0.3	21.1	6.9	0.7	10.6	1.9
Colorado	315.8	14.8	4.4	9.6	15.6	23.1	4.4	0.8
Connecticut	594.9	19.3	4.3	7.5	10.0	38.6	3.5	0.7
Delaware	70.5	21.6	2.9	3.2	13.9	33.7	7.6	0.6
District of Columbia	297.7	37.2	9.0	1.6	7.2	19.1	6.7	0.3
Florida	943.1	22.4	0.7	7.0	12.3	30.5	3.8	0.9
Georgia	759.6	27.9	0.0	9.6	8.1	18.7	9.6	1.5
Hawaii	140.4	24.0	0.0	14.8	6.3	27.7	11.4	3.7
Idaho	76.3	18.7	0.0	11.0	20.9	26.7	7.8	1.0
Illinois	1,652.9	35.4	0.8	7.1	13.1	20.3	6.4	0.2
Indiana	746.7	22.6	0.5	10.4	5.5	33.6	8.2	1.5
Iowa	359.9	21.4	0.7	0.7	16.9	29.0	11.3	3.9
Kansas	256.3	17.5	4.5	0.8	19.3	32.3	7.1	2.0
Kentucky	539.8	27.6	2.0	7.7	7.4	22.2	11.2	1.3
Louisiana	725.3	21.6	1.9	0.7	18.9	26.3	4.3	1.0
Maine	232.4	20.6	0.0	1.5	10.7	39.4	6.2	0.8
Maryland	583.9	31.0	2.7	1.1	6.4	32.3	6.4	0.8
Massachusetts	1,432.6	27.2	0.5	12.7	16.0	17.3	3.4	1.2
Michigan	1,516.6	29.1	3.3	6.3	10.4	18.9	9.6	1.5
Minnesota	1,001.1	13.9	1.1	31.0	20.2	13.6	5.5	1.2
Mississippi	274.4	22.0	0.0	16.1	8.5	19.1	11.3	2.2
Missouri	524.9	22.3	0.3	1.8	10.0	38.2	6.9	1.7
Montana	95.5	19.9	0.0	1.3	8.5	41.6	8.3	2.8
Nebraska	167.1	19.8	2.4	5.8	14.4	31.9	7.9	1.6
Nevada	65.7	23.1	0.4	3.1	13.4	32.6	9.3	1.7
New Hampshire	118.0	11.3	3.9	0.7	12.6	49.1	1.9	0.4
New Jersey	1,144.7	25.2	4.3	3.1	14.5	26.0	3.9	1.8
New Mexico	148.3	31.3	0.0	1.2	11.7	25.7	10.2	1.8
New York	7,588.0	23.2	8.6	23.6	12.8	4.1	2.7	0.7
North Carolina	646.7	25.0	2.2	17.2	17.3	15.1	6.3	1.7
North Dakota	116.7	16.7	2.9	24.7	15.7	17.9	6.0	2.0
Ohio	1,767.4	28.5	1.0	17.1	10.6	11.6	7.3	1.4
Oklahoma	460.4	26.9	5.0	0.2	11.7	30.9	9.7	0.9
Oregon	238.7	13.9	2.0	1.8	21.8	30.1	6.0	0.8
Pennsylvania	1,797.4	20.3	5.4	6.7	19.2	29.2	2.6	1.7
Puerto Rico	139.1	35.6	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	250.0	31.9	0.5	1.4	17.5	35.0	2.1	0.7
South Carolina	309.4	21.7	3.5	13.4	17.1	18.2	8.5	1.2
South Dakota	94.4	20.9	2.7	1.7	16.8	36.3	4.8	0.7
Tennessee	577.8	20.5	2.8	3.7	11.0	28.9	8.4	1.0
Texas	1,413.9	19.0	0.0	2.4	18.8	29.6	10.6	0.8
Utah	109.7	23.5	3.1	1.9	21.9	25.5	10.8	1.9
Vermont	89.4	17.6	1.0	1.1	14.3	32.4	6.8	0.9
Virgin Islands	4.1	47.4	0.0	0.0	0.0	0.0	0.9	3.0
Virginia	546.9	19.4	3.9	3.4	17.4	30.1	6.7	0.8
Washington	584.1	21.7	1.3	28.0	17.4	1.5	7.6	1.8
West Virginia	173.2	33.3	0.1	14.7	1.5	21.4	10.2	1.8
Wisconsin	942.2	13.9	2.0	31.9	7.2	18.8	4.1	1.0
Wyoming	28.2	26.1	1.5	6.7	0.0	46.5	11.5	1.6

See footnote at end of table.

Table 4.17—Continued

Percent of Medicaid payments, by type of service and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	Type of service							
	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
	Percent							
All jurisdictions	0.7	4.8	1.9	0.9	3.0	6.2	0.5	2.7
Alabama	0.4	2.7	0.5	1.6	2.8	10.1	1.2	0.8
Alaska	0.9	4.4	2.7	0.1	0.1	0.0	0.5	5.0
Arkansas	0.4	2.0	2.0	0.1	1.0	10.5	0.3	3.3
California	1.1	5.2	2.7	2.0	0.1	6.5	0.6	2.9
Colorado	0.9	3.3	5.9	0.5	8.9	5.8	0.5	1.4
Connecticut	0.6	5.5	1.0	0.2	1.5	4.8	0.4	2.1
Delaware	0.4	7.1	0.1	0.2	2.2	5.1	1.2	0.3
District of Columbia	0.2	6.4	5.4	0.4	2.0	3.1	0.1	1.4
Florida	0.3	3.0	1.1	0.8	2.5	9.0	0.1	5.6
Georgia	0.4	6.0	1.6	0.1	2.2	11.1	0.7	2.5
Hawaii	0.7	2.9	0.4	0.8	0.3	5.1	0.8	1.1
Idaho	0.7	3.7	1.1	1.1	1.2	3.6	0.3	2.1
Illinois	0.5	2.9	1.1	1.2	1.8	6.6	0.8	1.9
Indiana	2.2	3.9	0.8	0.1	0.4	7.1	0.6	2.7
Iowa	1.1	3.9	0.4	0.1	0.9	6.9	1.2	1.4
Kansas	0.6	3.1	1.6	0.7	0.6	7.2	0.7	2.0
Kentucky	0.4	5.0	3.4	0.1	4.1	6.3	0.7	0.6
Louisiana	0.9	4.3	1.3	5.2	0.4	9.6	0.7	3.0
Maine	1.0	5.1	0.7	0.1	4.5	7.0	0.6	1.8
Maryland	0.5	8.0	0.4	0.4	1.8	6.4	1.0	0.8
Massachusetts	0.6	7.8	3.0	0.3	2.3	4.5	0.3	2.9
Michigan	0.6	5.3	0.1	1.1	0.5	6.5	1.2	5.7
Minnesota	1.3	1.9	0.5	0.1	0.7	4.2	0.3	4.5
Mississippi	0.4	4.4	0.0	0.3	0.6	13.2	0.9	1.1
Missouri	0.6	5.8	3.2	0.4	0.8	6.4	0.7	0.9
Montana	1.8	3.0	1.1	0.1	0.3	5.9	0.5	4.9
Nebraska	1.3	2.7	0.1	0.9	0.9	8.5	0.3	1.5
Nevada	0.3	3.2	0.1	0.5	3.6	5.3	0.5	3.1
New Hampshire	0.4	2.5	2.4	0.1	8.6	4.4	0.2	1.5
New Jersey	0.6	6.3	3.2	0.5	1.9	6.8	0.5	1.3
New Mexico	0.7	4.7	0.4	0.3	1.0	7.5	0.8	2.8
New York	0.5	4.8	2.7	0.7	9.1	3.3	0.3	2.8
North Carolina	0.4	3.0	1.1	1.3	1.5	7.0	0.4	0.5
North Dakota	0.6	1.4	1.0	0.3	3.1	4.8	0.3	2.6
Ohio	0.9	7.1	1.4	0.3	0.1	9.5	0.1	3.1
Oklahoma	0.1	1.4	0.2	0.0	0.0	4.3	0.2	8.6
Oregon	0.3	3.7	2.2	2.2	4.2	6.8	0.8	3.4
Pennsylvania	0.3	2.3	2.7	0.7	0.2	6.6	0.5	1.5
Puerto Rico	0.0	64.4	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	0.2	3.8	0.0	0.1	0.3	5.0	0.2	1.2
South Carolina	0.0	3.2	1.0	0.1	1.0	8.0	0.5	2.5
South Dakota	0.2	2.2	0.6	1.2	5.8	4.4	0.2	1.4
Tennessee	0.5	3.9	3.8	1.4	1.0	11.0	0.5	1.4
Texas	0.7	2.9	0.0	1.1	5.1	7.5	0.6	0.9
Utah	0.8	3.1	0.5	0.2	0.4	5.4	0.2	1.1
Vermont	0.6	3.4	12.2	0.1	1.8	6.6	0.4	0.7
Virgin Islands	0.0	36.0	0.0	0.3	0.1	8.0	1.0	3.4
Virginia	0.2	4.6	1.2	0.7	1.9	7.8	0.4	1.6
Washington	1.2	4.9	0.0	1.4	0.9	5.2	0.5	6.6
West Virginia	0.8	2.5	0.6	0.5	0.5	7.3	0.9	3.9
Wisconsin	0.5	4.3	2.3	1.5	1.8	5.1	0.8	4.8
Wyoming	0.7	3.9	0.0	0.3	0.2	0.0	0.7	0.4

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Table 4.18

Per capita personal income, percent of population below the poverty level, and payment per Medicaid recipient, by jurisdiction: Fiscal year 1985

State	Per capita personal income	Percent of population below poverty level[1]	Payment per Medicaid recipient
U.S. average	$13,451	12.4	$1,848
Alabama	10,510	18.9	1,187
Alaska	17,756	10.7	2,768
Arkansas	10,180	19.0	1,816
California	15,255	11.4	1,197
Colorado	14,413	10.1	2,144
Connecticut	17,627	8.0	2,736
Delaware	14,337	11.8	1,738
District of Columbia	17,909	18.6	3,029
Florida	13,397	13.4	1,678
Georgia	12,158	16.6	1,620
Hawaii	13,542	9.9	1,522
Idaho	10,605	12.6	1,965
Illinois	14,397	11.0	1,554
Indiana	12,276	9.7	2,630
Iowa	12,779	10.1	1,698
Kansas	14,046	10.1	1,809
Kentucky	10,585	17.6	1,322
Louisiana	11,015	18.6	1,743
Maine	11,423	13.0	1,868
Maryland	15,356	9.8	1,776
Massachusetts	15,790	9.6	2,739
Michigan	13,298	10.4	1,338
Minnesota	14,071	9.5	2,802
Mississippi	9,035	23.9	916
Missouri	12,784	12.2	1,474
Montana	10,728	12.3	2,019
Nebraska	13,699	10.7	1,779
Nevada	13,981	8.7	2,328
New Hampshire	14,308	8.5	3,129
New Jersey	16,368	9.5	1,969
New Mexico	10,741	17.6	1,698
New York	15,237	13.4	3,384
North Carolina	11,314	14.8	1,884
North Dakota	13,034	12.6	3,183
Ohio	12,979	10.3	1,691
Oklahoma	12,215	13.4	1,706
Oregon	12,165	10.7	1,565
Pennsylvania	12,959	10.5	1,678
Rhode Island	13,592	10.3	2,482
South Carolina	10,514	16.6	1,302
South Dakota	11,207	16.9	2,790
Tennessee	10,934	16.4	1,596
Texas	13,165	14.7	1,857
Utah	10,166	10.3	1,519
Vermont	11,599	12.1	1,775
Virginia	14,146	11.8	1,805
Washington	13,267	9.8	1,789
West Virginia	10,112	15.0	819
Wisconsin	12,883	8.7	1,991
Wyoming	12,955	7.9	1,444

[1] 1979 data.

SOURCES: Per capita income: U.S. Department of Commerce, Bureau of Economic Analysis. Poverty population: U.S. Department of Commerce, Bureau of the Census: Data from the 1980 census. Payment per recipient: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Financing

Under Medicaid, service providers (physicians, pharmacists, hospitals, etc.) are financed by different sources, including:

- The Federal Government, through Federal matching assistance payments.
- The Federal Government, through Medicare Part B (supplementary medical insurance) buy-in agreements.
- State governments.
- Local governments (in some cases).
- Third parties who are liable for care provided to Medicaid eligibles.
- Medicaid recipients themselves.

Data on each source of funds except private third-party payments and expenditures contributed by Medicaid recipients themselves are presented in this section.

Federal share of State financing

The Federal share of State medical vendor payments is determined by a statutory formula based on State per capita income, where

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times .45$$

and Federal share equals 1.00 minus the State share. By design, the formula sets higher rates of Federal matching (up to a statutory maximum of 83 percent) for States with relatively low per capita incomes and lower rates (down to a minimum of 50 percent) for States with relatively high per capita incomes.

The Federal Medicaid assistance percentages (FMAP's) in effect since the enactment of Medicaid are shown in Table 4.19. During fiscal years 1984 and 1985, no jurisdiction received the maximum Federal match of 83 percent; 17 received the minimum; and Mississippi received the highest, 77.6 percent. These percentages apply to medical vendor payments only.

Although FMAP's are calculated for the territories, the total amount of Federal Medicaid funds payable to the territories is limited by law. The following limits, set by the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), went into effect in fiscal year 1988.

American Samoa	$1,330,000
Guam	2,320,000
Northern Marianas	636,700
Puerto Rico	73,400,000
Virgin Islands	2,430,000

For fiscal year 1985, Federal matching rates for other expenditures were as follows.

- Family planning services were matched at 90 percent.
- Administrative costs were matched at 50 percent.
- Development of automated claims processing and management information systems was matched at 90 percent, and the operation of such systems was matched at 75 percent.

Table 4.19

Federal Medicaid assistance percentages, by jurisdiction: Selected years 1966–86

Medicaid jurisdiction	Jan. 1, 1966–June 30, 1967	July 1, 1969–June 30, 1971	July 1, 1973–June 30, 1975	July 1, 1975–Sept. 30, 1977	Oct. 1, 1977–Sept. 30, 1979	Oct. 1, 1979–Sept. 30, 1981	Oct. 1, 1981–Sept. 30, 1983	Oct. 1, 1983–Sept. 30, 1985	Oct. 1, 1985–Sept. 30, 1986
Alabama	79.85	78.54	75.93	73.79	72.58	71.32	71.13	72.14	72.30
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Arizona	63.94	66.42	61.92	60.48	60.81	61.47	59.87	61.21	62.28
Arkansas	81.67	79.76	76.31	74.60	72.06	72.87	72.16	73.65	73.83
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	53.08	56.24	57.22	54.69	53.71	53.16	52.28	50.00	50.00
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Florida	65.21	64.10	60.95	57.34	56.65	58.94	57.92	58.41	56.16
Georgia	74.91	71.48	66.96	66.10	65.82	66.76	66.28	67.43	66.05
Guam	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Hawaii	52.97	50.75	50.00	50.00	50.00	50.00	50.00	50.00	51.00
Idaho	70.73	68.91	69.50	68.18	63.38	65.70	65.40	67.28	69.36
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	55.77	52.85	57.01	57.47	57.86	57.28	56.73	59.93	62.82
Iowa	60.39	55.27	59.72	57.13	51.96	56.57	55.35	55.24	58.90
Kansas	61.45	57.78	55.37	54.02	52.35	53.52	52.50	50.67	50.00
Kentucky	76.70	74.30	72.12	71.37	69.71	68.07	67.95	70.72	70.23
Louisiana	76.41	73.57	72.80	72.41	70.45	68.82	66.85	64.45	63.81
Maine	69.57	68.33	70.03	70.60	69.74	69.53	70.63	70.63	68.86
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00	51.62	51.75	53.56	50.13	50.00
Michigan	50.31	50.00	50.00	50.00	50.00	50.00	50.00	50.70	56.79
Minnesota	60.46	56.95	57.37	56.84	55.26	55.64	54.39	52.67	53.41
Mississippi	83.00	83.00	80.55	78.28	78.09	77.55	77.36	77.63	78.42
Missouri	53.90	59.29	59.94	58.98	60.66	60.36	60.38	61.40	60.62
Montana	62.86	64.72	66.08	63.21	61.10	64.28	65.34	64.41	66.38
Nebraska	60.39	57.25	57.86	55.59	53.46	57.62	58.12	57.13	57.11
Nevada	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Hampshire	61.31	59.18	62.05	60.28	62.85	61.11	59.41	59.45	54.92
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	70.73	71.48	72.01	73.29	71.84	69.03	67.19	69.39	68.94
New York	50.00	50.00	50.00	50.00	50.00	50.00	50.88	50.00	50.00
North Carolina	75.58	73.96	70.01	68.03	67.81	67.64	67.81	69.54	69.18
North Dakota	66.67	70.48	70.12	57.59	50.71	61.44	62.11	61.32	55.12
Ohio	52.33	52.42	53.59	53.39	55.46	55.10	55.10	55.44	58.30
Oklahoma	70.32	68.84	68.07	67.42	65.42	63.64	59.91	58.47	57.60
Oregon	54.12	56.35	59.40	59.04	57.29	55.66	52.81	57.12	61.54
Pennsylvania	54.38	54.60	55.14	55.39	55.11	55.14	56.78	56.04	56.72

See footnote at end of table.

Table 4.19—Continued

Federal Medicaid assistance percentages, by jurisdiction: Selected years 1966–86

Medicaid jurisdiction	Jan. 1, 1966–June 30, 1967	July 1, 1969–June 30, 1971	July 1, 1973–June 30, 1975	July 1, 1975–Sept. 30, 1977	Oct. 1, 1977–Sept. 30, 1979	Oct. 1, 1979–Sept. 30, 1981	Oct. 1, 1981–Sept. 30, 1983	Oct. 1, 1983–Sept. 30, 1985	Oct. 1, 1985–Sept. 30, 1986
Puerto Rico	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Rhode Island	56.13	51.70	55.37	56.55	57.00	57.81	57.77	58.17	56.33
South Carolina	81.30	78.68	75.00	73.58	71.93	70.97	70.77	73.51	72.70
South Dakota	71.05	69.91	70.25	67.23	63.80	68.78	68.19	68.31	67.82
Tennessee	76.86	74.62	72.28	70.43	68.88	69.43	68.53	70.66	70.20
Texas	67.27	65.66	63.53	63.59	60.66	58.35	55.75	54.37	53.56
Utah	66.30	68.23	69.95	70.04	68.98	68.07	68.64	70.84	72.62
Vermont	68.44	64.96	65.38	69.82	68.02	68.40	69.37	68.59	67.06
Virgin Islands	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Virginia	66.96	65.04	61.58	58.34	57.01	56.54	56.74	56.53	53.14
Washington	50.81	50.00	53.13	53.72	51.64	50.00	50.00	50.00	50.06
West Virginia	74.27	75.73	73.52	71.90	70.16	67.35	67.95	70.57	71.53
Wisconsin	57.60	55.21	60.02	59.91	58.53	57.95	58.02	56.87	57.54
Wyoming	55.47	60.38	60.99	60.94	53.44	50.00	50.00	50.00	50.00

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of State Agency Financial Management.

- Costs of skilled nursing facility inspectors were matched at 75 percent.
- Costs of professional medical personnel used to administer the program were matched at 75 percent.
- State Medicaid fraud and abuse units located organizationally outside of the single State agency were matched at 90 percent for the first 3 years of their operation and 75 percent thereafter.

The share of total expenditures for medical assistance borne by the States varies with the extent to which States provide medical assistance to State-only eligibles and offer services that do not qualify for Federal financial participation.

Section 2161 of OBRA-81 reduced the total Federal reimbursement for each State by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. The specified reduction was computed on the total Federal Medicaid reimbursement claimed by each State in that year. However, a State could lower its annual reduction rate by 1 percentage point for each of three conditions: operation of a qualified hospital cost review program, an unemployment rate exceeding 150 percent of the national average, and fraud and abuse recoveries (including third-party liability recoveries in fiscal year 1982) equal to 1 percent of Federal payments to the State (42 CFR 433, subpart E).

In addition to the conditions cited previously, section 2161 of OBRA-81 allowed for a decrease in the designated reduction in Federal matching dollars for each State that kept its spending levels within a target rate of growth. For fiscal year 1982, the target level was set at 109 percent (that is, a 9-percent rate of growth) of each State's estimate of the Federal share of its fiscal year 1981 spending level. For fiscal years 1983 and 1984, target levels were based on changes in the medical care component of the Consumer Price Index. In each year, $1 was deducted from a State's scheduled reduction in Federal matching funds for every dollar in State spending below the target level. (For purposes of calculating the target rates only, section 137 of TEFRA removed the effect of changes in FMAP's for the States after fiscal year 1981.)

Beginning in fiscal year 1983, section 133 of TEFRA requires that Federal matching funds to States with eligibility error rates greater than 3 percent be reduced by the amount of the excess erroneous expenditures. The Secretary of DHHS is permitted to waive the penalty retroactively in certain limited cases based on a determination that the State made a good-faith effort to reduce its error rate to 3 percent. Several factors are considered in calculating the error rate:

- Inclusion of payments for services for ineligible recipients and overpayments for services for eligible recipients.
- Payments for services that a third party was liable to pay.
- Exclusion of technical errors.

Total administration and training payments and medical vendor payments eligible for Federal financial participation (FFP), along with the Federal and State share of such payments in fiscal year 1985, are shown in Table 4.20. These expenditure data may differ from expenditure figures in other tables because total payments computable for Federal funding are limited to payments for which FFP is allowed. Payments for which FFP is not allowed, such as Medicare supplementary medical insurance (SMI) premiums paid on behalf of the medically needy, are excluded. The Federal share reflects accounting adjustments, such as changes in payments to cost-reimbursed providers following year-end audits.

Local funding formulas

The non-Federal share of medical vendor payments may be provided out of State or local revenues. However, a State plan must ensure that at least 40 percent of the non-Federal share is borne directly by the State. It must also guarantee that lack of local funds will not result in smaller amounts, duration, scope, or quality of care provided to Medicaid eligibles. As of March 1985, 14 States provided for local funding of the non-Federal share of Medicaid vendor payments. The local funding formulas used by these States are presented in Table 4.21.

State buy-in with Medicare

If individuals eligible for Medicaid under a State plan also qualify for Medicare SMI coverage, the State can enroll them by paying their SMI premiums. Under this buy-in arrangement, some of the cost of providing care that would otherwise be borne by the State is instead borne by the Federal Government. (A more detailed discussion can be found in Chapter 1.)

The number of individuals enrolled in Medicare SMI under a buy-in arrangement as of calendar year 1985 is shown in Table 4.22. Also included are the number of such individuals receiving reimbursed services and the total payments made under the SMI program on behalf of Medicaid beneficiaries. All but five jurisdictions (Alaska, Louisiana, Oregon, Puerto Rico, and Wyoming) buy into the SMI program.

Administration

Methods of reimbursement and cost containment

Medicaid regulations specify several criteria and methods for reimbursing providers. The method of reimbursement for inpatient hospital services, outpatient hospital services, long-term care, and physicians' services as of March 1986 is presented by State in Table 4.23.

Before fiscal year 1982, States were required by law to reimburse inpatient hospital services on the same basis as Medicare, reasonable costs, unless the Secretary of DHHS approved an alternative method of reimbursement. This requirement was dropped by section 2173 of OBRA-81.

Table 4.20

Medicaid payments eligible for Federal financial participation, by type of payment and jurisdiction: Fiscal year 1985

Medicaid jurisdiction	All payments	Type of payment					
		Medical assistance			Administration and training		
		Total computable	Federal share	State share	Total computable	Federal share	State share
		Amount in millions					
United States	$41,258.1	$39,258.0	$21,661.2	$17,596.8	$2,000.1	$1,182.5	$817.6
Alabama	495.0	479.3	346.7	132.6	15.7	10.8	4.9
Alaska	69.0	64.4	32.8	31.6	4.6	2.5	2.1
American Samoa	3.2	3.2	1.2	2.0	0.0	0.0	0.0
Arizona[1]	104.6	96.2	60.8	35.4	8.4	4.2	4.2
Arkansas	390.6	372.3	274.3	98.0	18.3	12.0	6.3
California	4,562.5	4,277.5	2,147.3	2,130.2	285.0	168.8	116.2
Colorado	337.7	321.8	161.4	160.4	15.9	10.7	5.2
Connecticut	608.4	579.9	290.4	289.5	28.5	16.4	12.1
Delaware	72.3	69.1	35.0	34.1	3.2	1.8	1.4
District of Columbia	320.6	306.1	153.3	152.8	14.5	8.5	6.0
Florida	990.5	955.5	558.2	397.3	35.0	20.2	14.8
Georgia	798.8	767.1	517.5	249.6	31.7	18.1	13.6
Guam	3.8	3.4	1.7	1.7	0.4	0.2	0.2
Hawaii	150.2	141.4	71.2	70.2	8.8	5.8	3.0
Idaho	79.6	74.9	50.5	24.4	4.7	3.1	1.6
Illinois	1,777.3	1,719.8	865.2	854.6	57.5	33.9	23.6
Indiana	763.1	736.1	442.5	293.6	27.0	15.5	11.5
Iowa	375.1	361.2	200.6	160.6	13.9	8.6	5.3
Kansas	273.4	261.3	133.2	128.1	12.1	7.2	4.9
Kentucky	577.5	554.4	392.3	162.1	23.1	16.0	7.1
Louisiana	764.5	738.7	477.5	261.2	25.8	15.2	10.6
Maine	259.5	247.2	174.9	72.3	12.3	7.4	4.9
Maryland	647.0	612.7	309.0	303.7	34.3	19.5	14.8
Massachusetts	1,664.2	1,598.0	805.4	792.6	66.2	33.4	32.8
Michigan	1,763.6	1,685.5	859.4	826.1	78.1	47.0	31.1
Minnesota	1,051.9	1,011.8	534.1	477.7	40.1	22.4	17.7
Mississippi	306.6	296.7	230.7	66.0	9.9	6.3	3.6
Missouri	576.4	556.1	342.3	213.8	20.3	11.4	8.9
Montana	105.3	97.8	63.3	34.5	7.5	4.8	2.7
Nebraska	178.5	168.2	96.3	71.9	10.3	6.1	4.2
Nevada	72.4	66.7	33.5	33.2	5.7	3.1	2.6
New Hampshire	126.9	118.4	70.4	48.0	8.5	5.4	3.1
New Jersey	1,233.7	1,165.5	585.3	580.2	68.2	45.1	23.1
New Mexico	161.7	153.4	107.3	46.1	8.3	5.4	2.9
New York	8,275.8	7,864.1	3,949.7	3,914.4	411.7	244.3	167.4
North Carolina	683.0	646.9	450.6	196.3	36.1	19.4	16.7
North Dakota	121.5	115.0	71.0	44.0	6.5	3.8	2.7
Northern Marianas	0.8	0.8	0.4	0.4	0.0	0.0	0.0
Ohio	1,814.7	1,754.1	973.6	780.5	60.6	35.3	25.3
Oklahoma	504.6	467.9	274.1	193.8	36.7	20.3	16.4
Oregon	286.3	252.6	145.1	107.5	33.7	19.8	13.9
Pennsylvania	2,016.8	1,908.4	1,075.5	832.9	108.4	64.9	43.5
Puerto Rico	146.0	139.2	60.0	79.2	6.8	3.4	3.4
Rhode Island	266.7	259.3	151.0	108.3	7.4	3.9	3.5
South Carolina	379.0	356.0	262.0	94.0	23.0	14.3	8.7
South Dakota	97.1	94.5	65.2	29.3	2.6	1.6	1.0
Tennessee	646.5	614.1	434.3	179.8	32.4	15.5	16.9
Texas	1,583.4	1,475.4	804.3	671.1	108.0	67.2	40.8
Utah	155.9	142.6	101.1	41.5	13.3	8.4	4.9
Vermont	97.0	88.6	61.5	27.1	8.4	5.4	3.0
Virgin Islands	4.7	4.2	2.1	2.1	0.5	0.3	0.2
Virginia	579.8	557.8	316.2	241.6	22.0	12.7	9.3
Washington	650.7	620.2	310.8	309.4	30.5	18.1	12.4
West Virginia	190.8	179.5	126.8	52.7	11.3	7.2	4.1
Wisconsin	1,062.2	1,027.6	586.5	441.1	34.6	18.9	15.7
Wyoming	29.4	28.2	14.2	14.0	1.2	0.6	0.6

[1] Pertains to Arizona Health Care Cost Containment System.

SOURCE: Health Care Financing Administration, Bureau of Quality Control: Data from the Division of Financial Management.

Table 4.21

Local funding formulas for Medicaid vendor payments, by State: March 1986

State	Formula
Colorado	20 largest counties pay 2 percent of State share for all new ICF admissions.
Florida	Counties pay: 35 percent of cost or $55.00 per month, whichever is less, for each nursing home resident; 35 percent of cost for 13th–45th inpatient hospital days.
Iowa	Counties match Federal funds for ICF's/MR.
Minnesota	Counties pay 10 percent of State share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 4.6 percent of total expenditures.
New Hampshire	Local contribution of approximately 28 percent of nursing home costs, excluding residents in State institutions.
New York	Counties pay 50 percent of non–Federal share except for long–term care, for which they pay 20 percent of non–Federal share.
North Carolina	Counties pay 15 percent of non–Federal share for all services.
North Dakota	Counties pay 15 percent of State share except for ICF's/MR, clinic services, and waivered home and community–based services for mentally retarded, aged, and disabled recipients.
Pennsylvania	Counties pay 10 percent of State share for county nursing homes plus $3 per invoice administration fee.
South Dakota	Local contribution of $60.00 per month for each ICF/MR resident and local school district for Crippled Children's Hospital.
Utah	Local contribution of less than 1 percent for specific services (e.g., mental health).
Wisconsin	Local contribution of 10–20 percent for mental health services.

NOTE: ICF is intermediate care facility. ICF/MR is intermediate care facility for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

States are now required only to provide assurances satisfactory to the Secretary that the rates paid to hospitals:

- Are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards.
- Take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, that serve large numbers of low–income patients.
- Provide reasonable access to inpatient hospital services of adequate quality.
- Are routinely documented through uniform cost reports filed by each hospital and through periodic State audits of such reports (42 CFR 447.252).

States must ensure that their payment systems for SNF and ICF services are reasonably related to cost. Use of a cost–related payment system for long–term care institutional services has been required by law since July 1, 1976, but became fully operational in different States at different times after that date. For all other services, States are free to choose their own method of payment as long as the aggregate Medicaid payment levels do not exceed the amounts that would be paid under Medicare.

As of March 1986, 16 States reported using Medicare principles for inpatient hospital services, 24 for outpatient hospital services, and 14 States for physicians' services.

Before October 1, 1981, Medicaid eligibles were free to choose any provider, practitioner, or supplier of health services covered by a State's Medicaid program. However, the Secretary of DHHS was authorized to waive any Federal Medicaid requirements to enable States to conduct experimental, pilot, or demonstration projects that limit freedom of choice, including prospective reimbursement demonstrations. To provide States more flexibility in implementing various cost–saving measures, section 2175 of OBRA–81 provides that a State will not be held out of compliance for failure to meet certain State plan requirements if it limits free choice in any of the following ways.

- Purchases laboratory services and medical devices through a competitive or other arrangement, if the Secretary finds that adequate services or devices were available to beneficiaries.
- Contracts with organizations that agree to provide services in addition to those offered under the State plan to eligible individuals who reside in the area served by the organization and elect to receive care from the organization.
- Pays for certified rural health clinic services.
- "Locks in" beneficiaries who overutilize services to a particular provider for a reasonable time period.
- "Locks out" providers who abuse the program subject to prior notice and opportunity for a hearing.

Table 4.22

Medicaid eligibles enrolled as Medicare buy-ins, persons served, and Medicare reimbursements, by jurisdiction: Calendar year 1985

Medicaid jurisdiction	Number of State buy-ins enrolled in thousands	Number of persons with reimbursed services[1] in thousands	Total reimbursements in millions
All jurisdictions	3,244.5	2,619.3	$2,762.0
Alabama	115.3	90.1	61.4
Alaska[2]	3.3	2.0	2.6
Arizona[3]	19.7	13.1	13.1
Arkansas	72.0	56.8	40.7
California	627.1	526.7	805.6
Colorado	37.1	30.9	27.9
Connecticut	15.2	12.7	13.8
Delaware	4.3	3.4	3.7
District of Columbia	14.1	10.8	16.6
Florida	153.1	123.5	163.1
Georgia	131.9	107.9	91.6
Guam	0.7	0.4	0.4
Hawaii	10.9	9.3	10.7
Idaho	7.8	6.7	4.3
Illinois	51.8	43.7	59.7
Indiana	51.4	44.4	33.3
Iowa	35.4	28.9	20.2
Kansas	27.2	23.0	18.4
Kentucky	66.3	47.0	28.6
Louisiana[2]	0.7	4.7	3.3
Maine	17.1	12.8	7.6
Maryland	49.4	40.8	44.1
Massachusetts	85.8	66.0	66.1
Michigan	75.6	61.7	69.4
Minnesota	17.7	14.8	12.5
Mississippi	94.5	75.5	49.6
Missouri	52.3	41.4	31.6
Montana	9.2	7.4	5.2
Nebraska	8.2	6.7	4.8
Nevada	6.0	5.5	7.6
New Hampshire	3.6	2.9	2.4
New Jersey	87.7	73.5	84.6
New Mexico	19.8	14.7	11.7
New York	213.4	173.4	192.5
North Carolina	72.9	63.1	52.7
North Dakota	3.9	3.3	2.8
Ohio	100.4	89.2	88.0
Oklahoma	45.4	33.5	22.4
Oregon[2]	24.9	21.6	20.6
Pennsylvania	99.1	74.9	92.4
Puerto Rico[2]	0.0	1.2	1.1
Rhode Island	10.7	8.4	8.0
South Carolina	72.4	55.0	32.6
South Dakota	6.0	4.3	3.1
Tennessee	90.4	66.5	49.9
Texas	249.9	201.7	196.9
Utah	8.7	7.1	5.6
Vermont	6.6	5.0	3.0
Virgin Islands	0.8	0.2	0.1
Virginia	71.1	59.4	55.0
Washington	51.3	43.3	41.8
West Virginia	24.4	17.3	13.5
Wisconsin	50.6	39.0	33.1
Wyoming[2]	0.0	0.1	0.2

[1] Based on supplementary medical insurance bills (physicians', outpatient, home health, and other services) paid January 1984–March 1985. Recipient counts and reimbursements correspond to the State of residence at the time the bill was processed, which need not be the State which bought in for that person.
[2] No buy-in agreement; therefore, the number of State buy-ins enrolled at any time is zero. However, recipient and reimbursement counts are attributed to the person's State of residence at the time the bill was processed.
[3] Pertains to Arizona Health Care Cost Containment System.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Entitlement Requirements.

Both lock-in and lock-out limits are subject to assurances that eligible individuals have reasonable access to services of adequate quality.

Additionally, the provision authorizes the Secretary to waive certain State plan requirements for a 2-year period in order to assist States in improving cost effectiveness in various areas of program operation, such as:

- Allowing States to create a primary care case management system or a physician specialty arrangement.
- Allowing a locality to act as a central broker, helping Medicaid beneficiaries select among competing health plans.
- Permitting States to share with recipients, in the form of additional services, savings resulting from the use of more cost-effective care.
- Restricting the providers from whom recipients can obtain services (in other than emergency situations) to those who agree to comply with reasonable State standards.

Federal regulations governing payments for prescription drugs, known as the maximum allowable cost (MAC) system, went into effect in August 1976 (42 CFR 447.332). MAC regulations place upper limits on government payments for certain multisource prescription drugs and require States to establish the estimated acquisition cost (EAC) of all outpatient drug products prescribed for Medicaid enrollees. The exception to this regulation is that a physician may specify in writing that a higher cost drug is required. For Federal matching purposes, payments for prescription drugs may not exceed the MAC limit (plus a reasonable dispensing fee), the EAC estimate (plus a reasonable fee), or the provider's usual and customary charge to the general public, whichever is lowest.

Table 4.23

Medicaid reimbursement methods, by type of service and jurisdiction: March 1986

Medicaid jurisdiction	Inpatient hospital services				Outpatient hospital services		Long-term care[2]			Physicians' services		
										Medicare principles (percent under prevailing charge)	Fee schedule	
	Medicare principles	Medicaid only[1]	Medicaid and private payers[1]	All payers[1]	Medicare principles	Other	SNF	ICF	ICF/MR		Fixed fee schedule	Relative value scale
Alabama	(3)					X	PFS	PFS	PFS	>75		
Alaska		1983				X	PFS	PFS	PFS	80		
Arkansas		1984				X	PC	PC	PFS		X	
California	(3)					X	PC	PC	PC			X
Colorado		1984				X	PFS	PFS	PFS			X
Connecticut	X					X	PFS	PFS	PFS		X	
Delaware	X				X		PFS	PFS	COM		X	
District of Columbia		1985			X		PFS	PFS	PFS		X	
Florida		1985			X		PC	PC	PFS		X	
Georgia		1983			X		PFS	PFS	PFS		X	
Hawaii	X					X	PFS	PFS	PFS	80		
Idaho		1980			X		RFS	RFS	RFS			X
Illinois		1985				X	PFS	PFS	PFS		X	
Indiana		1983				X	PC	PC	PC		X	
Iowa		1982			X		PFS	PFS	PFS		X	
Kansas		1983			X		PFS	PFS	PFS	75		
Kentucky	X					X	PFS	PFS	PFS	75		
Louisiana	X				X		PC	PC	PC	75		
Maine				1984		X	RFS	PFS	PFS		X	
Maryland				1977		X	COM	COM	COM		X	
Massachusetts			1984			X	RFS	RFS	PFS		X	
Michigan		1985				X	PFS	PFS	PFS		X	
Minnesota	X					X	PFS	PFS	PFS			X
Mississippi	(3)				X		PFS	PFS	PFS		X	
Missouri		1981				X	PFS	PFS	PFS		X	
Montana	X				X		PFS	PFS	RFS		X	
Nebraska	(3)					X	PFS	PFS	PFS	75		
Nevada		1983				X	COM	COM	PFS		X	
New Hampshire	(3)				X		RFS	COM	PFS		X	
New Jersey				1979	X		PFS	PFS	RFS		X	
New Mexico		1985			X		PFS	PFS	RFS	75		
New York	(3)					X	PFS	PFS	PFS		X	
North Carolina		1981			X		PFS	PFS	PFS		X	
North Dakota	X				X		COM	COM	RFS	75		
Ohio	X				X		COM	COM	COM	>75		

See footnotes at end of table.

Table 4.23—Continued

Medicaid reimbursement methods, by type of service and jurisdiction: March 1986

Medicaid jurisdiction	Inpatient hospital services				Outpatient hospital services		Long-term care[2]			Physicians' services		
										Medicare principles (percent under prevailing charge)	Fee schedule	
	Medicare principles	Medicaid only[1]	Medicaid and private payers[1]	All payers[1]	Medicare principles	Other	SNF	ICF	ICF/MR		Fixed fee schedule	Relative value scale
Oklahoma		1983				X	PC	PC	PC	75		
Oregon	X				X		PFS	PFS	COM		X	
Pennsylvania	X					X	COM	COM	COM		X	
Rhode Island			1977			X	PFS	PFS	PFS		X	
South Carolina	X				X		PFS	PFS	RFS			X
South Dakota	X				X		COM	COM	COM		X	
Tennessee	([3])				X		PFS	RFS	RFS	85		
Texas	X				X		PC	PC	PC	75		
Utah		1983				X	COM	COM	COM			X
Vermont		1982			X		PFS	PFS	RFS		X	
Virginia		1982			X		PFS	PFS	RFS		X	
Washington		1985				X	PFS	PFS	PFS		X	
West Virginia	X					X	PFS	PFS	PFS		X	
Wisconsin	([3])					X	COM	COM	COM		X	
Wyoming	X				X		PFS	PFS	([4])	75		

[1] Year of implementation of alternative reimbursement system.
[2] Facilities: SNF is skilled nursing facility; ICF is intermediate care facility; ICF/MR is intermediate care facility for the mentally retarded. Reimbursement methods: PFS is prospective facility-specific; RFS is retrospective facility-specific; PC is prospective class rate; COM is combination of other methods.
[3] Medicare and Medicaid principles used.
[4] Does not provide ICF/MR services.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicaid Estimates and Statistics.

Prior to October 1, 1981, States could enter into prepaid risk contracts only with federally qualified health maintenance organizations (HMO's). Contracting HMO's were required to have an enrollment consisting of less than 50 percent Medicaid and Medicare beneficiaries. Section 2178 of OBRA-81 allows States to enter into prepaid risk contracts not only with qualified HMO's but also with other organizations that make covered services accessible to Medicaid enrollees to the same extent that these services are accessible to Medicaid recipients not enrolled with the organization and have made adequate provision against the risk of insolvency. Participating organizations also must assure that Medicaid enrollees will not be held liable for debts in the event of the organization's insolvency. Additionally, contracts must provide for:

- Access by the Secretary of DHHS and the State to certain books and records of the organization.
- Nondiscrimination on the basis of health status or use of health services in the organization's enrollment, reenrollment, and disenrollment activities.
- Disenrollment rights for individuals after one full month of membership.
- Reimbursement for medically necessary services received out of plan (under certain circumstances).

Section 2178 also requires States to continue Medicaid eligibility to the end of an HMO's minimum enrollment period for Medicaid-covered HMO enrollees who would otherwise lose their Medicaid eligibility. It raises the previous enrollment limit from no more than 50 percent to no more than 75 percent Medicare and Medicaid beneficiaries. Section 2178 also allows the Secretary to modify or waive this last requirement for public HMO's when warranted by special circumstances and when the HMO is making reasonable efforts to enroll individuals from the private sector.

State administration and training

Administration of State Medicaid programs is vested in single State agencies. State plans must designate a medical assistance unit within each agency that is responsible for developing, analyzing, and evaluating the Medicaid program. The law further requires States to establish medical care advisory committees to counsel the Medicaid agency director about health and medical services. These committees must include board-certified physicians and other representatives of the health profession, members of consumer groups, and the director of either the State public welfare department or the public health department (whichever department does not run the Medicaid program).

Medicaid regulations establish certain standards governing personnel administration in State Medicaid programs. First, each State must employ a merit system of personnel administration. Second, the State plan must offer a training program for agency personnel. This program must include inservice training for new staff, be related to job duties, and be consistent with program objectives. Finally, the State plan must provide for the training and effective use of subprofessional staff and unpaid volunteers. Federal financial participation is available to States for administrative and training costs.

Provider participation

In Table 4.24, the number of enrolled and participating physicians and Medicare-Medicaid certified beds in general hospitals, SNF's, ICF's, and ICF's for the mentally retarded is shown. Enrolled physicians are generally defined as physicians who have applied for and received a Medicaid provider number. Providers are certified for enrollment regardless of their participation status. Participating physicians are defined as enrolled physicians who have submitted at least one claim within the past 12-month period.

Eligibility determination level

States are allowed several options for administering mandatory coverage of Supplemental Security Income recipients:

- Under section 1634 of the Social Security Act, States electing to extend Medicaid to all SSI recipients can enter into an agreement with the Social Security Administration. Under this agreement, the Social Security Administration determines what people are eligible for SSI and the State automatically issues Medicaid identification cards to those people.
- Alternatively, States electing to extend Medicaid eligibility to all SSI recipients can make eligibility determinations on a State level, requiring that SSI recipients file a separate Medicaid application with the State.
- States electing the 209(b) option (in which recipients of SSI cash assistance are not automatically eligible for Medicaid) apply different eligibility criteria from SSI, require cash assistance recipients to make a separate application for Medicaid, and determine eligibility at the State level.

The option chosen by each State is listed in Table 4.25. As of March 1986, 31 States had elected Federal determination, 5 States had elected to extend Medicaid to all SSI recipients but to maintain eligibility determination on a State level, and 14 had elected to retain their 209(b) status.

Table 4.24

Enrolled and participating physicians and Medicaid–certified beds, by type of provider and jurisdiction: March 1986

Medicaid jurisdiction	Physicians		Certified beds							
					SNF[1]		ICF[2]		SNF–ICF	
	Enrolled	Participating	General hospital	Swing–beds	Medicaid certified	Dually certified[3]	ICF other than for mentally retarded	ICF for mentally retarded	Medicaid certified	Dually certified[3]
United States	503,642	319,121	899,946	9,179	376,326	438,242	447,854	149,217	72,450	501,742
Alabama	9,688	9,688	21,424	—	4,403	10,571	1,135	1,419	0	6,466
Alaska	450	—	1,123	0	395	184	41	104	0	579
Arkansas	4,615	1,063	—	219	13,493	1,395	6,402	1,529	0	0
California	45,845	31,703	92,775	250	35,862	66,262	2,534	9,596	0	7,582
Colorado	6,922	—	12,914	225	9,357	2,499	1,440	1,318	0	11,856
Connecticut	4,791	2,594	10,510	0	2,159	18,803	2,249	1,474	—	19,604
Delaware	1,100	1,100	—	—	209	1,321	434	474	0	983
District of Columbia	4,022	1,812	5,456	0	0	420	802	341	0	262
Florida	18,190	14,104	—	—	29,443	15,751	158	3,261	27,367	45,173
Georgia	8,500	8,500	25,960	0	23,500	6,296	2,715	2,240	0	27,514
Hawaii	2,570	2,570	—	—	243	1,786	780	378	0	1,384
Idaho	4,112	1,617	3,449	13	2,000	2,783	84	536	0	4,783
Illinois	22,282	16,055	60,479	768	41,917	7,160	23,955	8,138	0	45,843
Indiana	12,726	7,225	24,896	0	1,454	9,936	22,526	3,835	0	3,857
Iowa	6,592	4,927	14,800	400	67	844	30,379	1,339	0	324
Kansas	8,729	4,611	—	64	2,258	810	20,622	2,231	—	2,100
Kentucky	15,221	2,537	18,786	8	6	3,624	9,459	1,203	0	42
Louisiana	8,285	3,994	22,810	153	212	3,130	28,783	6,129	0	1,329
Maine	3,253	1,619	5,138	0	58	370	7,719	834	0	0
Maryland	13,220	4,968	20,043	0	0	10,544	7,047	2,256	0	10,544
Massachusetts	11,580	11,580	28,294	0	16,195	6,785	10,924	4,036	0	41
Michigan	19,453	—	[4]39,745	0	12,191	23,250	9,739	4,091	0	33,283
Minnesota	13,079	8,351	20,416	332	25,313	11,993	7,003	7,817	—	24,352
Mississippi	6,119	4,290	15,730	1,148	11,534	349	1,183	1,572	9,830	8,840
Missouri	14,327	5,730	31,764	224	16,091	4,444	9,369	1,841	22,321	20,391
Montana	1,528	1,528	—	211	1,955	2,204	756	316	0	4,159
Nebraska	2,023	1,062	6,021	1,860	2,415	1,097	12,631	855	2,242	2,722
Nevada	1,700	1,650	6,315	100	0	2,264	182	187	0	2,163
New Hampshire	2,356	481	3,547	276	202	440	4,723	377	0	0
New Jersey	9,356	4,650	30,031	0	20,451	13,427	1,636	3,881	—	33,771
New Mexico	3,822	1,629	5,005	151	0	397	3,712	704	0	0
New York	43,811	38,496	73,039	0	313	84,148	5,524	16,995	0	0
North Carolina	9,585	4,145	28,487	528	10,554	9,510	11,878	3,139	0	0
North Dakota	1,955	609	4,077	1,013	1,301	3,467	1,450	857	0	4,768
Ohio	27,478	23,378	50,206	0	0	39,997	29,366	8,078	0	36,222

See footnotes at end of table.

Table 4.24—Continued

Enrolled and participating physicians and Medicaid-certified beds, by type of provider and jurisdiction: March 1986

Medicaid jurisdiction	Physicians		Certified beds							
					SNF[1]		ICF[2]		SNF-ICF	
	Enrolled	Participating	General hospital	Swing-beds	Medicaid certified	Dually certified[3]	ICF other than for mentally retarded	ICF for mentally retarded	Medicaid certified	Dually certified[3]
Oklahoma	10,000	10,000	19,500	0	106	0	28,330	3,206	0	0
Oregon	9,526	5,239	8,213	0	748	1,089	6,868	2,131	0	47
Pennsylvania	24,645	17,498	66,451	0	10,666	27,740	10,680	8,358	0	37,736
Rhode Island	1,657	1,657	4,748	0	0	2,363	7,141	1,019	0	0
South Carolina	5,550	3,879	11,565	0	92	8,211	1,828	2,751	0	8,087
South Dakota	2,777	1,229	3,831	314	4,656	322	2,459	806	0	4,978
Tennessee	10,646	5,507	27,156	0	0	4,610	17,745	1,565	0	2,617
Texas	22,781	17,776	—	0	5,334	7,546	71,221	14,410	0	9,577
Utah	4,225	1,893	5,100	350	0	4,280	1,472	1,304	0	0
Vermont	2,800	2,400	2,601	20	63	592	1,286	271	0	0
Virginia	9,269	7,658	20,175	0	0	2,186	10,627	3,167	0	88
Washington	12,295	5,429	12,481	105	22,691	2,352	1,112	2,835	10,690	25,058
West Virginia	4,753	3,493	10,734	0	88	3,084	4,741	109	0	3,136
Wisconsin	12,303	6,067	23,694	—	44,664	5,398	2,642	3,904	0	47,606
Wyoming	1,130	1,130	457	447	1,667	208	362	0	0	1,875

[1] Skilled nursing facility.
[2] Intermediate care facility.
[3] Certified by Medicare and Medicaid.
[4] Excludes State and Federal institutions.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Rapid Access Data Retrieval System (Long-Term Care).

Table 4.25

Medicaid Supplemental Security Income eligibility determination and status of Medicaid Management Information System, by jurisdiction: March 1986

Medicaid jurisdiction	Supplemental Security Income eligibility determination[1]			Medicaid Management Information System			
	Section 1634	State determination	209(b) State	Certified	Certification anticipated fiscal year 1986	Implementation planned	None
Alabama	Y	N	N	Y	N	N	N
Alaska	N	Y	N	N	N	N	Y
Arkansas	Y	N	N	Y	N	N	N
California	Y	N	N	Y	N	N	N
Colorado	Y	N	N	Y	N	N	N
Connecticut	N	N	Y	Y	N	N	N
Delaware	Y	N	N	N	N	N	Y
District of Columbia	Y	N	N	Y	N	N	N
Florida	Y	N	N	Y	N	N	N
Georgia	Y	N	N	Y	N	N	N
Hawaii	N	N	Y	Y	N	N	N
Idaho	N	Y	N	Y	N	N	N
Illinois	N	N	Y	Y	N	N	N
Indiana	N	N	Y	Y	N	N	N
Iowa	Y	N	N	Y	N	N	N
Kansas	N	Y	N	Y	N	N	N
Kentucky	Y	N	N	Y	N	N	N
Louisiana	Y	N	N	Y	N	N	N
Maine	Y	N	N	Y	N	N	N
Maryland	Y	N	N	N	N	N	Y
Massachusetts	Y	N	N	N	N	N	Y
Michigan	Y	N	N	Y	N	N	N
Minnesota	N	N	Y	Y	N	N	N
Mississippi	Y	N	N	Y	N	N	N
Missouri	N	N	Y	Y	N	N	N
Montana	Y	N	N	Y	N	N	N
Nebraska	N	N	Y	Y	N	N	N
Nevada	N	Y	N	N	N	N	Y
New Hampshire	N	N	Y	Y	N	N	N
New Jersey	Y	N	N	Y	N	N	N
New Mexico	Y	N	N	Y	N	N	N
New York	Y	N	N	Y	N	N	N
North Carolina	N	N	Y	Y	N	N	N
North Dakota	N	N	Y	Y	N	N	N
Ohio	N	N	Y	Y	N	N	N
Oklahoma	N	N	Y	Y	N	N	N
Oregon	N	Y	N	Y	N	N	N
Pennsylvania	Y	N	N	Y	N	N	N
Rhode Island	Y	N	N	N	N	N	Y
South Carolina	Y	N	N	Y	N	N	N
South Dakota	Y	N	N	Y	N	N	N
Tennessee	Y	N	N	N	N	Y	N
Texas	Y	N	N	Y	N	N	N
Utah	N	N	Y	Y	N	N	N
Vermont	Y	N	N	Y	N	N	N
Virginia	N	N	Y	Y	N	N	N
Washington	Y	N	N	Y	N	N	N
West Virginia	Y	N	N	Y	N	N	N
Wisconsin	Y	N	N	Y	N	N	N
Wyoming	Y	N	N	N	N	N	Y

[1] Eligibility determination for the territories is based on separate regulations, found in 42 *Code of Federal Regulations* 436.

NOTE: Y is yes; N is no.

SOURCES: Health Care Financing Administration, Bureau of Eligibility Reimbursement and Coverage: Data from the Division of Eligibility Policy; Bureau of Program Operations: Data from the Division of Medicaid Procedures.

Medicaid Management Information System

The 1972 Amendments to the Social Security Act authorized 90-percent Federal matching to States for the costs of design, development, and installation of mechanized claims processing and information retrieval systems and 75-percent matching for the costs of operating such systems.

The Medicaid Management Information System (MMIS) is a general conceptual design that can be tailored by State Medicaid agencies to their own particular needs so long as the system meets federally required minimum performance standards. The conceptual design includes six subsystems: recipient, provider, claims processing, reference file, surveillance and utilization review, and management and administration reporting. The first four subsystems work together with the overall objective of processing and paying each eligible provider for every valid claim. The other two subsystems consolidate and organize data necessary for managing and controlling the Medicaid program.

State progress in developing and implementing MMIS-type systems as of March 1986 is summarized in Table 4.25. Forty-two States had mechanized claims processing and information retrieval systems approved for 75 percent FFP. One State was in the planning, development, or installation phase, and seven States had no active Federal MMIS plan. Statutory authority for MMIS development is section 235 of Public Law 92-603. Regulations are published in 42 CFR 433, subpart C.

Review for fraud and abuse

Under Federal law, a State plan must specify criteria and methods for identifying suspected fraudulent use of the Medicaid program, methods for investigating cases, and procedures for referring suspected fraud to law enforcement officials.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1980 further authorized 90 percent FFP for the establishment and operation of Medicaid fraud control units in each State. Each unit must be a single identifiable entity located outside the Medicaid agency (for example, in the Office of the State's Attorney General). Fraud control units are responsible for investigating and prosecuting (or referring for prosecution) violations of State Medicaid laws, reviewing complaints alleging abuse or neglect of patients, recovering overpayments, and investigating recipient fraud. Staff of such units must include attorneys, auditors, and investigators. To receive FFP at the 90-percent rate, the unit must be certified by the U.S. Department of Health and Human Services. In fiscal year 1985, 36 Medicaid fraud control units were certified.

Medicaid data system

The majority of Medicaid data presented in this report came from a compilation of the annual Medicaid report (HCFA-2082 report) submitted to HCFA by the State Medicaid agencies. States obtained this information from their own Medicaid claims processing and payment operations.

The major claims processing and payment system used in the States is the Medicaid Management Information System. The general system design for State systems, completed and distributed by HCFA in 1972, allows for considerable variation in certain MMIS characteristics. This flexibility is congruent with the program diversity existing among the States.

Creating standardized reports for systems employing nonstandard coding, processing, and file structures is obviously difficult. Compounding these difficulties is the programmatic diversity inherent in Medicaid itself. For example, the cross-county variation inherent in the New York State program leads to considerable problems in the creation of a State-level report. As a consequence of these and other factors, approximately six States do not file an annual report in any year. In any month, approximately two States do not file a monthly report. Historically, data for nonreporting States have been estimated by using weighted linear extrapolation methods and aggregating data from other reports. It should be noted that, on several occasions, information supplied by the States in subsequent years has been used to refine or correct data for previous years or provide missing data. Hence, data contained in this report may differ from those published previously.

References

Eggers, P.W.: Trends in Medicare reimbursement for end stage renal disease, 1974–1979. *Health Care Financing Review.* Vol. 6, No. 4. HCFA Pub. No. 03176. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Sept. 1984.

Klarman, H.E., Rice, D.P., Cooper, B.S., and Stettler, H.L.: *Sources of Increase in Selected Medical Care Expenditures, 1929–1969.* Staff Paper No. 4. Social Security Administration, Office of Research and Statistics, Apr. 1970.

McMillan, A., Lubitz, J., and Newton, M.: Trends in physician assignment rates for Medicare services, 1968–84. *Health Care Financing Review.* Vol. 7, No. 2. HCFA Pub. No. 03220. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Feb. 1986.

Ruther, M.: Medicare: Deductible and coinsurance amounts by beneficiaries using short-stay inpatient hospitals, 1983–84. *Research Brief.* No. 87–3. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md. 1987.

Waldo, D.R., Levit, K.R., and Lazenby, H.: National health expenditures, 1985. *Health Care Financing Review.* Vol. 8, No. 1. HCFA Pub. No. 03224. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Oct. 1986.

Appendix A
Medicare carriers and intermediaries

Blue Cross Association

Blue Cross and Blue Shield Association
676 North St. Clair Street
Chicago, Illinois 60611

Blue Cross plans

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Alaska—See Blue Cross of Washington and Alaska

Blue Cross and Blue Shield of Arizona, Inc.
2444 W. Las Palmaritas Drive
Phoenix, Arizona 85021
Mailing address:
P.O. Box 13466
Phoenix, Arizona 85002

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91470
Mailing address:
P.O. Box 70000
Van Nuys, California 91470

Rocky Mountain Hospital and Medical Service
(d.b.a. Blue Cross and Blue Shield of Colorado)
700 Broadway
Denver, Colorado 80273

Blue Cross and Blue Shield of Connecticut, Inc.
370 Bassett Road
North Haven, Connecticut 06473

Blue Cross and Blue Shield of Delaware, Inc.
One Brandywine Gateway
P.O. Box 1991
Wilmington, Delaware 19899

Group Hospitalization and Medical Services, Inc.
(d.b.a. Blue Cross and Blue Shield of the National Capitol Area)
550 Twelfth Street, SW.
Washington, D.C. 20024

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2711
Jacksonville, Florida 32201

Blue Cross and Blue Shield of Georgia, Inc.
2357 Warm Springs Road
P.O. Box 7368
Columbus, Georgia 31908

Blue Cross of Idaho Health Service, Inc.
1501 Federal Way
P.O. Box 7408
Boise, Idaho 83707

Health Care Service Corp.
233 North Michigan Avenue
Chicago, Illinois 60601

Associated Insurance Companies, Inc.
(d.b.a. Blue Cross and Blue Shield of Indiana)
120 West Market Street
Indianapolis, Indiana 46204

Blue Cross of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Cross of Western Iowa and South Dakota
Hamilton Blvd. and I–29
Sioux City, Iowa 51102

Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Boulevard
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40223

Louisiana Health Service and Indemnity Company
(d.b.a. Blue Cross of Louisiana)
5527 Reitz Avenue
Baton Rouge, Louisiana 70820–7006

Associated Hospital Service of Maine
(d.b.a. Maine Blue Cross and Blue Shield)
110 Free Street
Portland, Maine 04101

Blue Cross and Blue Shield of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Cross of Massachusetts
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
P.O. Box 64357
St. Paul, Minnesota 55164

Blue Cross and Blue Shield of Mississippi, Inc.
P.O. Box 1043
Jackson, Mississippi 39216

Blue Cross Hospital Service, Inc., of Missouri
4444 Forest Park
St. Louis, Missouri 63108

Blue Cross of Montana
3360 10th Avenue, South
P.O. Box 5017
Great Falls, Montana 59403

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Main Post Office Station
Omaha, Nebraska 68180

New Hampshire–Vermont Health Service
Two Pillsbury Street
Concord, New Hampshire 03301

Hospital Service Plan of New Jersey
33 Washington Street
Newark, New Jersey 07102

New Mexico Blue Cross and Blue Shield, Inc.
12800 Indian School Road, NE.
Albuquerque, New Mexico 87112

Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, North Carolina 27702

NOTE: d.b.a. means "doing business as."

Blue Cross of North Dakota
4510 13th Avenue, SW.
Fargo, North Dakota 58121

Community Mutual Insurance Company
1351 William Howard Taft Road
P.O. Box 14189
Cincinnati, Ohio 45214

Group Health Service of Oklahoma, Inc.
1215 South Boulder Avenue
Tulsa, Oklahoma 74119

Blue Cross and Blue Shield of Oregon
100 SW. Market Street
P.O. Box 1271
Portland, Oregon 97201

Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Blue Cross of Western Pennsylvania
One Smithfield Street
Pittsburgh, Pennsylvania 15222

Blue Cross and Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

South Dakota—See Blue Cross of Western Iowa and South Dakota

Blue Cross and Blue Shield of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402

Blue Cross and Blue Shield of Texas, Inc.
901 South Central Expressway
P.O. Box 833815
Richardson, Texas 75083-3815

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270
Salt Lake City, Utah 84130

Blue Cross and Blue Shield of Virginia
2015 Staples Mill Road
P.O. Box 27401
Richmond, Virginia 23279

Blue Cross of Washington and Alaska
7001-220th, SW.
P.O. Box 327
Mountlake Terrace, Washington 98043

Blue Cross and Blue Shield of West Virginia, Inc.
P.O. Box 231
Charleston, West Virginia 25325

Blue Cross and Blue Shield United of Wisconsin
401 West Michigan Street
P.O. Box 2025
Milwaukee, Wisconsin 53201

Blue Cross and Blue Shield of Wyoming
4000 House Avenue
P.O. Box 2266
Cheyenne, Wyoming 82001

Blue Shield plans

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

California Physicians Service
(d.b.a. Blue Shield of California)
No. 2 Northpoint
P.O. Box 7013
San Francisco, California 94120

Rocky Mountain Hospital and Medical Service
(d.b.a. Blue Cross and Blue Shield of Colorado)
700 Broadway
Denver, Colorado 80273

Delaware—See Pennsylvania Blue Shield

District of Columbia—See Pennsylvania Blue Shield

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 1798
Jacksonville, Florida 32201

Health Care Service Corporation
233 North Michigan Avenue
Chicago, Illinois 60601

Associated Insurance Companies, Inc.
(d.b.a. Blue Cross and Blue Shield of Indiana)
Medicare Department
120 West Market Street
Indianapolis, Indiana 46204

Blue Shield of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Boulevard
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
1218 Harrodsburg Road
Lexington, Kentucky 40504

Louisiana—See Arkansas Blue Cross and Blue Shield, Inc.

Maine—See Blue Shield of Massachusetts, Inc.

Blue Cross and Blue Shield of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02110

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
P.O. Box 64357
St. Paul, Minnesota 55164

Blue Cross and Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Montana Physicians' Service
404 Fuller Avenue
P.O. Box 4310
Helena, Montana 59601

Nebraska—See Blue Shield of Iowa

NOTE: d.b.a. means "doing business as."

Blue Shield of Western New York
298 Maine Street
Buffalo, New York 14202

Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Blue Shield of North Dakota
4510 13th Avenue, SW.
Fargo, North Dakota 58121

Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, Pennsylvania 17011

Seguros de Servicio de Salud de Puerto Rico, Inc.
G.P.O. Box 3628
San Juan, Puerto Rico 00936

Blue Cross and Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

South Dakota—See Blue Shield of North Dakota

Blue Cross and Blue Shield of Texas, Inc.
901 South Central Expressway
P.O. Box 833815
Richardson, Texas 75083-3815

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270, Medicare B
Salt Lake City, Utah 84130

Washington Physicians Service
4th & Battery Building, 6th Floor
2401 4th Avenue
Seattle, Washington 98121

Wisconsin Physicians' Service Insurance Corporation
1717 West Broadway
Madison, Wisconsin 53713

Commercial, independent, State, and other

Aetna Life and Casualty Company
151 Farmington Avenue
Hartford, Connecticut 06156

Cooperativa de Seguros de Vida de Puerto Rico
G.P.O. Box 3428
San Juan, Puerto Rico 00936

The Equitable Life Assurance Society of the United States
1285 Avenue of the Americas
New York, New York 10019

General American Life Insurance Company
13045 Tesson Ferry Road
St. Louis County, Missouri 63128

Group Health, Incorporated
330 West 42nd Street
New York, New York 10036

Hawaii Medical Service Association
818 Keeaumoku
P.O. Box 860
Honolulu, Hawaii 96808

Mutual of Omaha Insurance Company
P.O. Box 456
Downtown Station
Omaha, Nebraska 68101

Nationwide Mutual Insurance Company
P.O. Box 57
Columbus, Ohio 43216

The Prudential Insurance Company of America
Tri-City Office, Drawer 471
Millville, New Jersey 08332

Transamerica Occidental Life Insurance Company
12th at Hill Street
P.O. Box 54905
Los Angeles, California 90054

The Travelers Insurance Company
One Tower Square
Hartford, Connecticut 06183

Railroad Retirement Board
844 Rush Street
Chicago, Illinois 60611

NOTE: d.b.a. means "doing business as"

Appendix B
Medicaid agencies and fiscal agents

Single State agencies and State medical assistance units

Alabama (Region IV):
Single State agency and medical assistance unit:
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, Alabama 36130
205 277–2710

Alaska (Region X):
Single State agency:
Alaska Department of Health and Social Services
P.O. Box H–01
Juneau, Alaska 99811–0601
907 465–3355

Medical assistance unit:
Division of Medical Assistance
Alaska Department of Health and Social Services
P.O. Box H–07
Juneau, Alaska 99811–0601

Arizona (Region IX):
Single State agency and medical assistance unit:
Arizona Health Care Cost Containment System Administration
801 East Jefferson Street
Phoenix, Arizona 85034
602 234–3655

Arkansas (Region VI):
Single State agency:
Arkansas Department of Human Services
Seventh and Main Streets
P.O. Box 1437
Little Rock, Arkansas 72203
501 371–1001

Medical assistance unit:
Office of Medical Services
Arkansas Division of Economic and Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203
501 371–1806

California (Region IX):
Single State agency:
California State Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 445–1248

Medical assistance unit:
California State Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 322–5824

Colorado (Region VII):
Single State agency:
Colorado Department of Social Services
P.O. Box 181000
Denver, Colorado 80218–0899
303 294–5800

Medical assistance unit:
Colorado Department of Social Services
P.O. Box 181000
Denver, Colorado 80218–0899
303 294–5901

Connecticut (Region I):
Single State agency:
Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566–2008

Medical assistance unit:
Medical Care Administration
Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566–2934

Delaware (Region III):
Single State agency:
Delaware Department of Health and Social Services
Administration Building
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421–6705

Medical assistance unit:
Medical Assistance Services
Delaware Department of Health and Social Services
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421–6139

District of Columbia (Region III):
Single State agency:
Department of Human Services
801 North Capital Street
Room 700
Washington, D.C. 20002
202 727–0450

Medical assistance unit:
Office of Health Care Financing/Office of the Controller
D.C. Department of Human Services
1331 H Street, NW.
Room 500
Washington, D.C. 20005
202 727–0735

Florida (Region IV):
Single State agency:
Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Florida 32301
904 488–7721

Medical assistance unit:
Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Building 6, Room 233
Tallahassee, Florida 32301
904 488–3560

Georgia (Region IV):
Single State agency and medical assistance unit:
Georgia Department of Medical Assistance
2 Martin Luther King Drive
1220 West Tower
Atlanta, Georgia 30334
404 656–4479

Guam (Region IX):
Single State agency and medical assistance unit:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910
671 734–2083

Hawaii (Region IX):
Single State agency:
Hawaii Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548–6260

Medical assistance unit:
Health Care Administration Division
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-3855

Idaho (Region X):
Single State agency:
Idaho Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-5500

Medical assistance unit:
Bureau of Medical Assistance
Idaho Department of Health and Welfare
450 W. State Street
Statehouse
Boise, Idaho 83720
208 334-5794

Illinois (Region V):
Single State agency:
Illinois Department of Public Aid
Jesse B. Harris Building II
2nd Floor
100 South Grand Avenue, East
Springfield, Illinois 62762
217 782-6716

Medical assistance unit:
Illinois Department of Public Aid
628 East Adams Street
3rd Floor
Springfield, Illinois 62761
217 782-2570

Indiana (Region V):
Single State agency:
Indiana Department of Public Welfare
State Office Building
100 North Senate Avenue
Room 701
Indianapolis, Indiana 46204
317 232-4705

Medical assistance unit:
Indiana Department of Public Welfare
100 North Senate Avenue
State Office Building, Room 702
Indianapolis, Indiana 46204
317 232-4324

Iowa (Region VII):
Single State agency:
Iowa Department of Human Services
Hoover State Office Building
5th Floor
Des Moines, Iowa 50319
515 281-5452

Medical assistance unit:
Bureau of Medical Services
Iowa Department of Human Services
Hoover State Office Building
5th Floor
Des Moines, Iowa 50319
515 281-8794

Kansas (Region VII):
Single State agency:
Kansas Department of Social and Rehabilitation Services
State Office Building, 6th Floor
Room 628-S
Topeka, Kansas 66612
913 296-3271

Medical assistance unit:
Kansas Department of Social and Rehabilitation Services
Room 628-S
State Office Building, 6th Floor
Topeka, Kansas 66612
913 296-3981

Kentucky (Region IV):
Single State agency and medical assistance unit:
Kentucky Department for Medicaid Services
CHR Building
275 East Main Street
Frankfort, Kentucky 40621
502 564-4321

Louisiana (Region VI):
Single State agency:
Louisiana Department of Health and Human Resources
P.O. Box 3776
Baton Rouge, Louisiana 70821
504 342-6711

Medical assistance unit:
Medical Assistance Programs
Louisiana Department of Health and Human Resources
P.O. Box 44065
Baton Rouge, Louisiana 70804
504 342-3956

Maine (Region I):
Single State agency:
Maine Department of Human Services
221 State Street
Statehouse, Station II
Augusta, Maine 04333
207 289-2736

Medical assistance unit:
Bureau of Medical Services
Whitten Road
Statehouse, Station II
Augusta, Maine 04333
207 289-2674

Maryland (Region III):
Single State agency:
Maryland Department of Health and Mental Hygiene
Herbert R. O'Connor Building
201 West Preston Street
Baltimore, Maryland 21201
301 225-6500

Medical assistance unit:
Maryland Department of Health and Mental Hygiene
Herbert R. O'Connor Building
201 West Preston Street
Room 524
Baltimore, Maryland 21201
301 225-6535

Massachusetts (Region I):
Single State agency:
Massachusetts Department of Public Welfare
180 Tremont Street
Boston, Massachusetts 02111
617 574-0200

Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5550

Medical assistance unit:
Massachusetts Department of Public Welfare
180 Tremont Street
Boston, Massachusetts 02111
617 574-0205

Medical assistance:
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5550

Michigan (Region V):
Single State agency:
Michigan Department of Social Services
300 South Capitol Avenue
P.O. Box 30037
Lansing, Michigan 48909
517 373-2000

Medical assistance unit:
Michigan Department of Social Services
921 West Holmes
P.O. Box 30037
Lansing, Michigan 48909
517 334-7262

Minnesota (Region V):
Single State agency:
Minnesota Department of Human Services
Centennial Office Building
4th Floor
658 Cedar Street
Saint Paul, Minnesota 55155
612 296-2701

Medical assistance unit:
Bureau of Income Maintenance
Minnesota Department of Public Welfare
Space Center Building, 1st Floor
444 Lafayette Road
Saint Paul, Minnesota 55101
612 296-2766

Mississippi (Region IV):
Single State agency and medical assistance unit:
Division of Medicaid
Office of the Governor
4785 I-55 North
P.O. Box 16786
Jackson, Mississippi 39236-0786
601 981-4507

Missouri (Region VII):
Single State agency:
Missouri Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65102
314 751-4815

Medical assistance unit:
Division of Medical Services
Missouri Department of Social Services
308 East High Street
P.O. Box 6500
Jefferson City, Missouri 65103
314 751-6922

Montana (Region VII):
Single State agency:
Montana Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-5622

Medical assistance unit:
Economic Assistance Division
Montana Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-4540

Nebraska (Region VII):
Single State agency:
Nebraska Department of Social Services
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402 471-3121

Medical assistance unit:
Nebraska Department of Social Services
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402 471-9330

Nevada (Region IX):
Single State agency:
Nevada Department of Human Resources
Kinkead Building—Capitol Complex
505 East King Street
Carson City, Nevada 89710
702 885-4730

Medical assistance unit:
Welfare Division
Department of Human Resources
Capitol Complex
2527 North Carson Street
Carson City, Nevada 89710
702 885-4698

New Hampshire (Region I):
Single State agency:
New Hampshire Department of Health and Human Services
6 Hazen Drive
Concord, New Hampshire 03301-6521
603 271-4331

Medical assistance unit:
Office of Medical Services
New Hampshire Division of Health and Human Services
6 Hazen Drive
Concord, New Hampshire 03301-6521
603 271-4353

New Jersey (Region II):
Single State agency:
New Jersey Department of Human Services
Capitol Place One
222 South Warren Street
Trenton, New Jersey 08625
609 292-3717

Medical assistance unit:
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
Building No. 7
Quakerbridge Plaza, CN 712
Trenton, New Jersey 08625
609 588-2600

New Mexico (Region VI):
Single State agency:
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503-2348
505 827-4072

Medical assistance unit:
Medical Assistance Division
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503-2348
505 827-4315

New York (Region II):
Single State agency:
New York State Department of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9475

Medical assistance unit:
Division of Medical Assistance
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243
518 474-9132

North Carolina (Region IV):
Single State agency:
North Carolina Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919 733-4534

Medical assistance unit:
Division of Medical Assistance
North Carolina Department of Human Resources
1985 Umstead Drive
Raleigh, North Carolina 27603
919 733-2060

North Dakota (Region VIII):
Single State agency:
North Dakota Department of Human Services
State Capitol Building
Bismarck, North Dakota 58505
701 224-2310

Medical assistance unit:
North Dakota Department of Human Services
State Capitol Building
Bismarck, North Dakota 58505
701 224-2321

Ohio (Region V):
Single State agency:
Ohio Department of Human Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43266-0423
614 466-6282

Medical assistance unit:
Ohio Department of Human Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43266-0423
614 466-3196

Oklahoma (Region VI):
Single State agency:
Oklahoma Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3646

Medical assistance unit:
Medical Services Division
Oklahoma Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 557-2540

Oregon (Region X):
Single State agency:
Oregon Department of Human Resources
318 Public Service Building
Salem, Oregon 97310
503 378-3034

Medical assistance unit:
Adult and Family Services Division
Oregon Department of Human Resources
203 Public Service Building
Salem, Oregon 97310
503 378-2263

Pennsylvania (Region III):
Single State agency:
Pennsylvania State Department of Public Welfare
Health and Welfare Building
Room 333
Harrisburg, Pennsylvania 17120
717 787-2600

Medical assistance unit:
Pennsylvania State Department of Public Welfare
Health and Welfare Building
Room 515
Harrisburg, Pennsylvania 17120
717 787-1870

Puerto Rico (Region II):
Single State agency:
Puerto Rico Department of Health
P.O. Box 70184
San Juan, Puerto Rico 00936
809 751-8259

Medical assistance unit:
Health Economy Office
Department of Health
P.O. Box 9342
San Juan, Puerto Rico 00936
809 765-9941

Rhode Island (Region I):
Single State agency:
Rhode Island Department of Human Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-2121

Medical assistance unit:
Rhode Island Department of Human Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-3575

South Carolina (Region IV):
Single State agency:
South Carolina State Health and Human Services Finance Commission
P.O. Box 8206
Columbus, South Carolina 29202-8206
803 253-6100

Medical assistance unit:
Bureau of Health Services
South Carolina State Health and Human Services Finance Commission
P.O. Box 8206
Columbus, South Carolina 29202-8206
803 253-6119

South Dakota (Region VIII):
Single State agency:
South Dakota Department of Social Services
Kneip Building
700 North Illinois Street
Pierre, South Dakota 57501
605 773-3165

Medical assistance unit:
Office of Medical Services
South Dakota Department of Social Services
Kneip Building
700 North Illinois Street
Pierre, South Dakota 57501
605 773-3495

Tennessee (Region IV):
Single State agency:
Tennessee Department of Health and Environment
344 Cordell Hull Building
Nashville, Tennessee 37219
615 741-0213

Medical assistance unit:
Bureau of Medicaid
Tennessee Department of Health and Environment
729 Church Street
Nashville, Tennessee 37219
615 741-0213

Texas (Region VI):
Single State agency:
Texas Department of Human Services
P.O. Box 2960
Austin, Texas 78769
512 450-3030

Medical assistance unit:
Texas Department of Human Services
P.O. Box 2960
Austin, Texas 78769
512 450–3050

Utah (Region VIII):
Single State agency:
Utah Department of Health
P.O. Box 16700
Salt Lake City, Utah 84116–0700
801 538–6111

Medical assistance unit:
Division of Health Care Financing
Utah Department of Health
P.O. Box 16580
Salt Lake City, Utah 84116–0580
801 538–6151

Vermont (Region I):
Single State agency:
Vermont Department of Social Welfare
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241–2220

Medical assistance unit:
Division of Medical Services
Vermont Department of Social Welfare
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241–2880

Virgin Islands (Region II):
Single State agency:
Virgin Islands Department of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774–0117

Medical assistance unit:
Bureau of Health Insurance and Medical Assistance
Virgin Islands Department of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 773–2150

Virginia (Region III):
Single State agency and medical assistance unit:
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
804 786–7933

Washington (Region X):
Single State agency and medical assistance unit:
Division of Medical Assistance
Washington Department of Social and Health Services
Mail Stop HB–41
Olympia, Washington 98504
206 753–1777

West Virginia (Region III):
Single State agency and medical assistance unit:
West Virginia Department of Human Services
1900 Washington Street, East
Charleston, West Virginia 25305
304 348–8990

Wisconsin (Region V):
Single State agency:
Wisconsin Department of Health and Social Services
1 West Wilson Street, Room 650
P.O. Box 7850
Madison, Wisconsin 53702
608 266–3681

Medical assistance unit:
Bureau of Health Care Financing
Wisconsin Department of Health and Social Services
1 West Wilson Street, Room 250
P.O. Box 309
Madison, Wisconsin 53701
608 266–2522

Wyoming (Region VIII):
Single State agency:
Wyoming Department of Health and Social Services
Hathaway Building
Cheyenne, Wyoming 82002
307 777–7121

Medical assistance unit:
Medical Assistance Services
Division of Health and Social Services
Hathaway Building, Room 450
Cheyenne, Wyoming 82002
307 777–7531

Medicaid fiscal agents and health insuring agencies

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Alabama	Alacaid	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, optometrist, home health, clinic, physical therapy, prescribed drugs, prosthetic devices, eyeglasses, intermediate care facility, nurse midwife, transportation, ambulatory surgical center.
Alaska	Computer Sciences Corporation	Hospital inpatient, hospital outpatient, physician, pharmacy, dental, nursing facility, EPSDT, other medical providers.
Arizona	No fiscal agent	
Arkansas	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, optometrist, chiropractor, clinic, dental, prescribed drugs, dentures, prosthetic devices, eyeglasses, rehabilitative, intermediate care facility, emergency hospital, personal care.
California	Computer Sciences Corporation	Inpatient, outpatient, long-term care, drugs, medical/professional, vision care. Crossover claims included.
Colorado	Computer Sciences Corporation	Inpatient, outpatient, physician, other practitioners, HCBS, transportation, supplies, laboratory and X-ray, dental, pharmacy, long-term care, EPSDT.
Connecticut	Electronic Data Systems Federal	Inpatient, outpatient, professional provider, dental, skilled nursing facility, intermediate care facility for the mentally retarded, long-term care, drug and pharmacy, optical, mental health. Crossover claims included.
Delaware	The Computer Company	Dental, drugs, inpatient, outpatient, EPSDT, physician, long-term care, intermediate care, home health, X-ray and laboratory, special services.
District of Columbia	The Computer Company	Physician, dental, pharmacy, home health, laboratory and X-ray, inpatient hospital, outpatient hospital, long-term care, transportation, health maintenance organization, vision care, durable medical equipment, EPSDT. Crossover claims included.
Florida	Electronic Data Systems	Inpatient hospital, outpatient hospital, physician, podiatry, ambulatory surgical, advanced registered nurse practitioner, birthing centers, community mental health, State mental health hospital, dental, EPSDT, family planning, health maintenance organization, hearing, waiver services, hospice care, home health, intermediate care facility for the mentally retarded, laboratory and X-ray, prescribed drugs, rural health clinic, vision, transportation, skilled and intermediate nursing home.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Georgia	Electronic Data Systems	Hospital inpatient and outpatient, nursing homes (State-owned skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded), pharmacy, ambulance, home health, durable medical equipment, orthotics and prosthetics, optical, mental health, EPSDT, family planning, nonemergency transportation, physician, osteopath, dentist, optometrist, podiatrist, psychologist, chiropractor, rural health therapy, nurse midwifery, out-of-State services.
Hawaii	Hawaii Medical Services Association	Professional medical, inpatient, outpatient, dental, drugs, durable medical equipment, vision, air transportation, EPSDT, long-term care. Crossover claims included.
Idaho	Electronic Data Systems Corporation	Hospital outpatient, inpatient, physician, dental, EPSDT, nursing home.
Illinois	No fiscal agent	
Indiana	Indiana Blue Cross/Blue Shield	Long-term care, inpatient hospital, outpatient hospital, dental, pharmacy, EPSDT, medical. Crossover claims included.
Iowa	Systems Development Corporation Integrated, Inc.	Inpatient hospital, outpatient hospital, physician, skilled nursing facility, laboratory and X-ray, home health, EPSDT, family planning clinics, drug, dental, chiropractor, podiatry, optometry, opticians, audiology, physical therapy, intermediate care facility, ambulance, durable medical equipment, psychologist, clinic.
Kansas	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, hearing aid dealer, laboratory and X-ray, Indian Health Service, ambulance, intermediate care facility, intermediate care facility for the mentally retarded, skilled nursing facility, physician, osteopath, rural health clinic, chiropractor, psychologist, podiatrist, optometrist, optician, audiologist, rehabilitation center, dentist, clinic, family planning, home health, pharmacy.
Kentucky	Electronic Data Systems	Prescribed drugs, physician, dental, inpatient hospital, outpatient hospital, ambulatory surgical center, renal dialysis, home health, vision, audiology, community mental health center, nurse midwife, family planning, home health, independent laboratory, birthing center, AIS/MR, home and community-based and adult day care, nurse anesthetist, podiatry, hospice screening, EPSDT, transportation, ambulance, primary care, rural health, mental hospital, long-term care facility, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Louisiana	Systems Development Corporation	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, clinic, dental, physical therapy, occupational therapy, speech, hearing, and language disorder, prescribed drugs, dentures, prosthetic devices, eyeglasses, rehabilitative, intermediate care facility.
Maine	No fiscal agent	
Maryland	No fiscal agent	
Massachusetts	Systems Development Corporation	Inpatient, outpatient, professional provider, transportation, dental, skilled nursing facility, intermediate care facility for the mentally retarded, drug and pharmacy, home health agency, optical, mental health, long-term care.
Michigan	No fiscal agent	
Minnesota	No fiscal agent	
Mississippi	Blue Cross/Blue Shield	Physician, inpatient, outpatient, pharmacy, long-term care claims, EPSDT, dental regular, EPSDT dental, eyeglasses, hearing aids, ambulance, transportation, ESC—pharmacy, inpatient, outpatient, transportation, home health. Crossover claims included.
Missouri	General American Consultec	Ambulance, audiologist, dentist, durable medical equipment, inpatient hospital, outpatient, home health, clinic, independent laboratory and X-ray, mental hospital, nursing home, optician, optometrist, pharmacy, physician, podiatrist, rehabilitation center, rural health clinic.
Montana	General American Consultec	Physician, inpatient, outpatient, nursing, dental, pharmacy.
Nebraska	No fiscal agent	
Nevada	Blue Cross/Blue Shield of Nevada	Inpatient, outpatient, skilled nursing facility, intermediate care facility, professional/medical, dental, drugs, EPSDT. Crossover claims included.
New Hampshire	Electronic Data Systems Federal	Inpatient, outpatient, professional provider, dental, skilled nursing facility, EPSDT, drugs, pharmacy. Crossover claims included.
New Jersey	Blue Cross/Blue Shield of New Jersey, Inc.	Inpatient hospital, outpatient hospital, pharmacy, hospital-based home health. Crossover claims included.
	The Prudential Insurance Company of America	Inpatient hospital, outpatient hospital, freestanding and hospital-based home health agency, physician, dental, transportation, durable medical equipment, EPSDT, prosthetics and orthotics, vision care clinic. Crossover claims included.
	Inhouse—Division of Medical Assistance and Health Services	Inpatient, long-term care, skilled nursing facility, intermediate care facility, institutions for tuberculosis and mental disease.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
New Mexico	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, podiatrist, optometrist, clinic, dental, physical therapy, prescribed drugs, dentures, prosthetic devices, eyeglasses, rehabilitative, intermediate care facility, emergency hospital.
New York	Computer Sciences Corporation	Pharmacy, inpatient, child care, diagnosis and treatment, dental, laboratory, clinical psychology, physician, outpatient, therapist, nursing, podiatry, long-term care.
North Carolina	Electronic Data Systems Federal	Inpatient hospital, outpatient hospital, laboratory and X-ray, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, home health, EPSDT, family planning, physician, rural health clinic, ambulance, prescribed drugs, chiropractor, podiatrist, optometrist, dental clinic, optical supplies, mental hospitals, personal care, health maintenance organizations, prepaid plans.
North Dakota	No fiscal agent	
Ohio	No fiscal agent	
Oklahoma	UNISYS	Inpatient hospital, outpatient hospital, rural health clinic, laboratory and X-ray, skilled nursing facility, EPSDT, family planning, physician, podiatrist, optometrist, dental, prescribed drugs, prosthetic devices, rehabilitative, intermediate care facility, personal care.
Oregon	No fiscal agent	
Pennsylvania	The Computer Company	Inpatient hospital, dental, podiatrist, optometrist, drug and alcohol abuse, home health, pharmacy, physician, ambulance, special services, laboratory and X-ray, outpatient clinic, long-term care, durable medical equipment, EPSDT.
Rhode Island	No fiscal agent	
South Carolina	No fiscal agent	
South Dakota	No fiscal agent	
Tennessee	The Computer Company	Inpatient and outpatient hospital, skilled nursing facility, home health, mental health, physician, laboratory and X-ray, vision, medical vendor, family planning, community health, ambulance, dental, pharmacy, EPSDT, intermediate care facility, home and community-based waiver services. Professional and professional crossover claims and special waiver project claims included.
Texas	National Heritage Insurance Company	All services except nursing home, prescribed drugs, adult day care, personal care in the recipient's home, transportation (other than ambulance).

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Utah	No fiscal agent	
Vermont	Electronic Data Systems Federal	Intermediate care facility, home health, optometrist, physician, podiatrist, ambulance, laboratory and X-ray, clinic, durable medical equipment, orthotics, prosthetics, rural health clinic, transportation.
Virginia	The Computer Company	Dental, drug, inpatient, outpatient, EPSDT, physician, skilled nursing care, intermediate care.
Washington	Consultec, Inc.	Hospital inpatient and outpatient, dental, physician, pharmacy, EPSDT, nursing home, other medical providers.
West Virginia	The Computer Company	Dental, drugs, hospital inpatient and outpatient, EPSDT, physician, other practitioners, clinic, laboratory and X-ray, transportation, durable medical equipment, medical supplies. Handicapped children programs claims included.
Wisconsin	Electronic Data Systems Federal	Drug, physician, dental, EPSDT, outpatient, medical vendor, inpatient, nursing home. Prior authorizations and crossover claims included.
Wyoming	No fiscal agent except for dental services	Automated: Dental for EPSDT.
	Dental (EPSDT) processed by Wyoming Dental Services	Manual: Inpatient, outpatient, physician, optometrist, home health, laboratory and X-ray, transportation.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Appendix C
Where to call for information

Medicare

Assignment of Medicare claims
Bureau of Eligibility, Reimbursement, and Coverage (301) 966-5648

Beneficiary assistance on claims and entitlement
Office of Program Operations Procedures
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Office of Program Administration
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Office of the Actuary (301) 966-7917

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Office of the Actuary (301) 966-7917

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Social Security Administration
Division of Program Management and Analysis
Office of Supplemental Security Income (202) 673-5747

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Division of Operational Initiatives
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Bureau of Program Operations (301) 966-7502

Utilization
Division of Medicaid Cost Estimates
Office of the Actuary (301) 966-7917

Appendix D
Glossary of Medicare and Medicaid terms

Aid to Families with Dependent Children (AFDC)—AFDC is a program of income support for low-income families that was established by title IV of the Social Security Act.

Aged—For purposes of Medicare enrollment, persons 65 years of age or over are considered to be aged. Medicaid eligibility is determined on the basis of financial need for people who meet Supplemental Security Income eligibility criteria (aged, blind, or disabled individuals) and Aid to Families with dependent Children criteria (adults and children). Eligibility determinations are made for an entire economic unit or "case" (sometimes a family) based on whether or not one member of a case meets the criteria. For example, an "aged" case could consist of a 66-year-old male and his 63-year-old wife. In contrast, a disabled enrollee could be over 65 years of age.

Assignment—An enrollee in the supplementary medical insurance program may agree with a provider of service to assign benefit rights to the provider. When this assignment method is used, the provider agrees to accept as the total charge for the covered service the amount that is approved by the carrier as the reasonable charge. The provider submits a claim to the carrier and is reimbursed for the reasonable charge, minus 20-percent coinsurance and any unmet deductible. The provider may then charge the enrollee only for the coinsurance and unmet deductible.

Automatic enrollment—Retirement and survivors insurance beneficiaries are automatically sent Medicare cards 3 months before they attain age 65; those entitled to disability benefits are automatically sent Medicare cards 3 months before the completion of 24 months of entitlement. These Medicare cards show entitlement to both hospital insurance and supplementary medical insurance (SMI). An enrollee wishing to decline SMI coverage must do so in writing no later than the month prior to the effective date of coverage.

Average compound rate of growth—Also called the average annual rate of change, this is a geometric rate of change in which a variable increases or decreases at the same rate each year. For example, an average annual rate of change of 10 percent, starting with a base of 100, would increase to 110 in the first year, 121 in the second year, and so on.

Benefit payments—These payments comprise all withdrawals from the Medicare hospital insurance and supplementary medical insurance trust funds for services rendered to Medicare enrollees. Payments include both reimbursements recorded on bills and payments made independently of the billing system (interim payments, end-of-year adjustments, and certain capitation payments).

Benefit period—A benefit period is the period used to limit Medicare benefits in the hospital insurance program. A benefit period begins the first day an enrollee is furnished inpatient hospital or extended care services by a qualified provider, and it ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Carrier—A carrier is an organization that has contracted with the Department of Health and Human Services to process claims and perform other services under Medicare's supplementary medical insurance program.

Categorically needy—Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who meet financial eligibility requirements for Aid to Families with Dependent Children, Supplemental Security Income, or an optional State supplement.

Coinsurance—Coinsurance is the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover. Under hospital insurance, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility (SNF) care; from the 21st through 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under supplementary medical insurance (SMI), after the annual deductible has been met, Medicare pays 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the enrollee. However, there is no coinsurance for home health services under SMI.

Copayment—Copayments are a type of cost sharing under Medicaid whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer pays the rest of the cost.

Covered services—Covered services under the Medicare program are the services and supplies for which Medicare will reimburse. Examples of covered services are given in this glossary under specific headings, such as skilled nursing facility services. Covered services under the Medicaid program consist of a combination of mandatory and optional services within each State.

Customary charge—Customary charges are the amounts physicians or suppliers usually bill patients for furnishing particular services or supplies.

Deductible—Deductibles are the amounts paid by enrollees for covered services before Medicare makes reimbursements. The hospital insurance deductible applies to each new benefit period, is determined each year by a formula specified by law, and approximates the current cost of a 1-day inpatient hospital stay. The supplementary medical insurance deductible is, by law, the first $75 of covered charges per calendar year, effective January 1, 1982.

Diagnosis-related group—Diagnosis-related groups are classifications used for incorporating severity-of-illness measurements into the process of determining prospective payment for inpatient hospital services.

Disabled—For purposes of Medicare enrollment, individuals under 65 years of age who have been entitled to disability benefits under the Social Security Act or the railroad retirement system for at least 24 months are considered disabled and are entitled to Medicare.

Discharge—A discharge is a formal release from a hospital or skilled nursing facility. Discharges include persons who died during their stay or were transferred to another facility.

Early and periodic screening, diagnosis, and treatment (EPSDT)—The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

End stage renal disease—Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have end stage renal disease. To qualify for Medicare coverage, such individuals must be fully or currently insured under social security or the railroad retirement system or be the dependent of an insured person. Eligibility for Medicare coverage begins the third month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility. Also, coverage may begin on admittance to a hospital to receive a kidney transplant or to receive dialysis before the transplant.

Enrollment period—Effective October 1, 1981, the general enrollment period for supplementary medical insurance is from January 1 through March 31 of each year. Coverage takes effect July 1. This constitutes a reinstatement of the general enrollment period after a period of continuous open enrollment.

Expenditure—Under Medicaid, an expenditure is an amount paid by a State agency for the covered medical expenses of eligible participants. (For Medicare, see "reimbursement.")

Family planning services—Family planning services are any medically approved means furnished or prescribed by or under the supervision of a physician to individuals of childbearing age for purposes of enabling such individuals freely to determine the number or spacing of their children. Diagnosis, treatment, drugs, supplies and devices, and related counseling are included.

Federal financial participation—Federal expenditures provided to match proper State expenditures made under approved State plans in accordance with the State's Federal Medicaid assistance percentage constitute Federal financial participation.

Federal hospital insurance trust fund—The Federal hospital insurance trust fund is a trust fund of the Treasury of the United States in which are deposited monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by social security. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program.

Federal supplementary medical insurance trust fund—The Federal supplementary medical insurance (SMI) trust fund is a trust fund of the Treasury of the United States consisting of amounts deposited in or appropriated to the fund as provided by title XVIII of the Social Security Act, including premiums paid by enrollees under SMI and contributions by the Federal Government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Fiscal agent—A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. Under Medicare, fiscal agents are called intermediaries (for hospital insurance) and carriers (for supplementary medical insurance).

Fiscal year—Fiscal years 1972-76 extended from July 1 through June 30. Beginning with October 1, 1977, fiscal years extend from October 1 through September 30.

General hospital—A general hospital is a hospital maintained primarily for inpatient care of acute illness or injury and for obstetrics.

Health maintenance organization (HMO)—Risk HMO's and competitive medical plans have contracts with Medicare on a prospective capitation payment basis for providing health care to Medicare beneficiaries.

Home health agency—A home health agency is a public or private organization that provides skilled nursing services and other therapeutic services in the patient's home and that meets certain conditions to ensure the health and safety of the individuals furnished services.

Home health services—Home health services are services and items furnished in patients' homes under the care of physicians. These services are furnished by home health agencies or by others under arrangements made by home health agencies. Services are furnished under a plan established and periodically reviewed by a physician. They include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biologicals); home health aide services; and services of interns and residents.

Hospital insurance—Hospital insurance (also known as Medicare Part A) is an insurance program providing basic protection against the costs of hospital and related posthospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for at least 24 months to disability benefits under the social security or railroad retirement systems, and for certain other individuals who are medically determined to have end stage renal disease and are covered by the social security or railroad retirement systems.

Independent laboratory—An independent laboratory is a laboratory certified to perform diagnostic tests independent of a physician's office or hospital and receive reimbursements from Medicare.

Inpatient hospital services—Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Intermediary—An intermediary is an organization selected by providers of health care that has an agreement with the Department of Health and Human Services to process claims and perform other functions under Medicare's hospital insurance program.

Intermediate care facility—An intermediate care facility is an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under title XIX (Medicaid) of the Social Security Act.

Laboratory and radiological services—These services are professional and technical laboratory and radiological services ordered by a licensed practitioner and provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified laboratory.

Lifetime reserve—A Medicare hospital insurance enrollee has a nonrenewable lifetime reserve of 60 days of inpatient hospital care to draw on if the 90 covered days per benefit period are exhausted.

Long-stay hospital—A long-stay hospital is one in which the average patient stay is 30 days or more.

Medically needy—Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children whose income resources are above the limits for eligibility as categorically needy but are within limits set under the Medicaid State plan and who are otherwise eligible for Medicaid.

Other practitioners' services—Other practitioners' services are health care services of licensed practitioners other than physicians and dentists.

Outpatient hospital services—Outpatient hospital services are services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

Outpatient services—Outpatient services are medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or freestanding dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, and X-ray and other radiation therapy.

Passthrough amounts—The Medicare payment rate for hospitals participating in the prospective payment system does not include passthrough costs, such as capital-related costs, direct medical education costs, and organ procurement costs. Under the prospective payment system, these passthrough costs continue to be reimbursed on a reasonable-cost basis.

Persons served—Under Medicare, a person served is a Medicare enrollee who used a covered medical service, who incurred expenses greater than the deductible amount, and for whom Medicare paid benefits.

Physicians' services—Under Medicare and Medicaid, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Portable X-ray—A portable X-ray is a radiograph taken with portable equipment, usually in the patient's place of residence, under the general supervision of a physician.

Premium—A premium is a monthly fee paid by Medicare enrollees. Hospital insurance (HI) enrollees who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. Supplementary medical insurance enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

Premium hospital insurance—Persons 65 years of age or over who are not automatically eligible for hospital insurance may obtain coverage by paying a monthly premium.

Prescribed drugs—Prescribed drugs are drugs dispensed by licensed pharmacists on the prescription of practitioners licensed by law to administer such drugs and drugs dispensed by licensed practitioners to their own patients. Drug charges that are not separable from a practitioner's other charges and drugs covered by a hospital bill are not included.

Prevailing charge—The prevailing charge is the charge at the 75th percentile in an array of the weighted customary charges made for similar services in the same locality. This is the upper limit of charges deemed "reasonable" for Medicare reimbursement.

Prospective payment system (PPS)—PPS is a Medicare system whereby hospitals are paid rates determined in advance for a specific unit of service. Each hospital keeps the difference between the payment rate and its costs, and each hospital is also at risk for any costs incurred above the prospective rate.

Psychiatric hospital—A psychiatric hospital is an institution primarily engaged in providing inpatients psychiatric services for the diagnosis and treatment of mental illness by or under the supervision of a physician.

Railroad retirement system—The railroad retirement system was mandated by the Railroad Retirement Act of 1937 as a retirement system for railroad employees.

Reasonable charge—In processing claims for supplementary medical insurance benefits, carriers use Health Care Financing Administration guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier, the charge the physician or supplier customarily bills patients for the same service, or the prevailing charge that most physicians or suppliers in that locality bill for the same service. Increases in physicians' prevailing charge levels are recognized by Medicare only to the extent justified by an index reflecting changes in the costs of practice and in general earnings.

Reasonable cost—In processing claims for hospital insurance (HI) benefits, intermediaries use Health Care Financing Administration guidelines to determine the reasonable cost incurred by individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the HI program.

Recipient—A Medicaid recipient is an individual who has been determined to be eligible for Medicaid and who has used medical services covered by Medicaid.

Reimbursement—The Medicare reimbursement amount includes only the amount shown in bills received and processed by the Medicare program in the Health Care Financing Administration central office files. Interim payments to institutional providers, payments to institutional providers resulting from adjustments to the end of fiscal year cost reports, and certain capitation payments for prepaid group health plans are excluded. (For Medicaid, see "expenditure.")

Rural health clinic—A rural health clinic is an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets certain other requirements designed to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not an urbanized area as defined by the U.S. Bureau of the Census and that is designated by the Secretary of the Department of Health and Human Services either as an area with a shortage of personal health services or as a health manpower shortage area. Rural health clinics must file an agreement with the Secretary not to charge an individual for items or services for which the person is entitled to have payment made by Medicare. An individual is charged only for the amount of any applicable deductible or coinsurance amount.

Short-stay hospital—A short-stay hospital is one in which the average length of stay is less than 30 days. General and special hospitals are included in this category.

Skilled nursing facility—A skilled nursing facility is an institution that has a transfer agreement with one or more participating hospitals, is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients, and meets specific regulatory certification requirements.

Skilled nursing facility services—All services furnished to inpatients of a certified skilled nursing facility that meets standards required by the Secretary of the Department of Health and Human Services and billed by the facility are included.

Spend-down—Spend-down refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.

State buy-in—This is the term given to the process by which a State may provide supplementary medical insurance coverage for its needy eligible persons by paying their premiums through an agreement with the Federal Government.

State plan—The Medicaid State plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Supplemental Security Income (SSI)—SSI is a program of income support for low-income aged, blind, and disabled persons that was established by title XVI of the Social Security Act.

Supplementary medical insurance (SMI)—Supplementary medical insurance (also known as Medicare Part B) is a voluntary insurance program that provides insurance benefits for physicians' and other medical services to aged and disabled individuals who elect to enroll under the program in accordance with the provisions of title XVIII of the Social Security Act. The program is financed by enrollee premium payments and contributions from funds appropriated by the Federal Government.

Third-party liability—Under Medicaid, third-party liability exists if there is any entity (including other government programs or insurance) that is liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Vendor—A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical services.

Appendix E
Medicare and Medicaid acronyms

AAPCC	Adjusted average per capita cost
ACRG	Annual compound rate of growth
AFDC	Aid to Families with Dependent Children
CFR	*Code of Federal Regulations*
CMHS	Continuous Medicare history sample
CMP	Competitive medical plan
DEFRA	Deficit Reduction Act
DHHS	Department of Health and Human Services
DRG	Diagnosis-related group
EAC	Estimated acquisition cost
EPSDT	Early and periodic screening, diagnosis, and treatment
ESRD	End stage renal disease
FFP	Federal financial participation
FMAP	Federal Medicaid assistance percentage
HCFA	Health Care Financing Administration
HHA	Home health agency
HI	Hospital insurance
HMO	Health maintenance organization
ICF	Intermediate care facility
ICF/MR	Intermediate care facility for the mentally retarded
MAC	Maximum allowable cost
MMIS	Medicaid Management Information System
OACT	Office of the Actuary
OBRA	Omnibus Budget Reconciliation Act
PPS	Prospective payment system
SMI	Supplementary medical insurance
SNF	Skilled nursing facility
SSI	Supplemental Security Income
TEFRA	Tax Equity and Fiscal Responsibility Act

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